

## ABILIFY MYCITE

---

### Products Affected

- Abilify Mycite Maintenance Kit
- Abilify Mycite Starter Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug: documentation of the medical necessity of tracking compliance with the prescribed treatment regimen.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ACTHAR HP

---

## Products Affected

- Acthar
- Cortrophin INJ 80UNIT/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Use of corticotropin intravenously. Corticotropin should not be used in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or active peptic ulcer disease, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin. Corticotropin is contraindicated in patients under the age of 2 with suspected congenital infections and for patients who also have adrenocortical insufficiency or adrenocortical hyperfunction.
<b>Required Medical Information</b>	Medical record documentation of one of the following conditions: 1) Infantile spasms, 2) Acute exacerbation of multiple sclerosis, 3) Exacerbation of rheumatic disorders including psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, 4) Exacerbation of or maintenance for collagen diseases including systemic lupus erythematosus, systemic dermatomyositis, 5) Dermatologic diseases including severe erythema multiforme, Stevens-Johnson Syndrome, 6) Allergic states such as serum sickness, 7) Ophthalmic diseases including keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, 7) Respiratory diseases such as symptomatic sarcoidosis or 8) Edematous condition from nephrotic syndrome or lupus erythematosus.
<b>Age Restrictions</b>	For infantile spasms: 2 years of age or younger
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Infantile spasms: until two years of age. All others: 1 month.
<b>Other Criteria</b>	For steroid responsive conditions, conditions number 2 to 7 listed in the Required Medical Information section: medical record documentation of failure of corticosteroid therapy in the last 30 days or reason why corticosteroids cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ACTIMMUNE

---

## Products Affected

- Actimmune INJ 100MCG/0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	T-cell lymphoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Prior authorization criteria does not apply to members already established on Actimmune for the treatment of T-cell lymphoma. 1. The use of Actimmune for T-cell lymphoma must be supported by Micromedex, AHFS-Drug Information, NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, or acceptable medical journals.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ADALIMUMAB

---

## Products Affected

- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter
- Adalimumab-adbm
- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter INJ 0

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Active non-radiographic axial spondyloarthritis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 4) Hidradenitis suppurativa (HS) initial: moderate to severe disease evident by documentation of Hurley Stage II or III. HS renewal: medical record documentation of a reduction in nodules or abscesses. 5) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 6) Psoriasis with arthropathy (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 7) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 8) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 9) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission. 10) Uveitis initial: documentation of non-infectious, intermediate, posterior or panuveitis. Renewal: documentation that treatment response is being monitored for the following development of new inflammatory chorioretinal and/or inflammatory retinal vascular lesions, anterior chamber cell grade or vitreous haze, or visual acuity.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC, ophthalmologist for uveitis, rheumatologist for AS, nr-axSpA, JIA, RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.

<b>Other Criteria</b>	AS and nr-axSpA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA initial: failure of an 8 week trial of methotrexate. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization), and 2) methotrexate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ADBRY

## Products Affected

- Adbry

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Atopic dermatitis initial (AD): body surface area involvement of at least 10% at baseline. 2) AD renewal criteria: medical record documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist, allergist, or immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Atopic dermatitis: failure of or contraindication to 1) one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and 2) tacrolimus ointment.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# AGAMREE

---

## Products Affected

- Agamree

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: genetic testing results confirming a diagnosis of Duchenne muscular dystrophy. Renewal criteria: documentation of a positive treatment response (e.g. pulmonary function, muscle strength, functional ability, walk tests).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of prednisone and deflazacort (requires PA).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# AIMOVIG

## Products Affected

- Aimovig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: 1) Episodic migraine: 4-14 headache days per month, 2) Chronic migraines: 15 or more headache days per month with at least 8 days of migraines for 3 months. Migraine renewal criteria: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime
<b>Other Criteria</b>	Documentation that Aimovig will not be used with a second CGRP agent for migraine prevention.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ALDURAZYME

---

## Products Affected

- Aldurazyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Diagnostic confirmation by presence of glycosaminoglycans (GAG) in the urine, deficiency in a-L-iduronidase enzyme activity, or genetic testing, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as improvement in percent predicted FVC, improvement in 6-minute walk test, reduction in urinary GAG levels, or reduction in liver size.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Dosing consistent with product label: 0.58 mg/kg IV once weekly.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ALOSETRON

## Products Affected

- Alosetron Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Constipation. 2) Intestinal obstruction, stricture, toxic megacolon, GI perforation and/or adhesions. 3) Ischemic colitis, impaired intestinal circulation. 4) Severe hepatic impairment. 5) Diverticulitis. 6) Hypercoaguable state. 6) Thrombophlebitis. 7) Crohn's disease or ulcerative colitis. 8) Concomitant use with apomorphine or fluvoxamine.
<b>Required Medical Information</b>	Initial: Medical record documentation of predominant symptom is severe diarrhea lasting at least 6 months and defined as frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, or disability or restriction of daily activities due to IBS. Renewal: Medical record documentation of a significant reduction in diarrhea frequency and abdominal pain and/or improvement in quality of life during the 8 week trial.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 8 weeks. Renewal: Lifetime.
<b>Other Criteria</b>	Failure of loperamide and dicyclomine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ALYFTREK

---

## Products Affected

- Alyftrek

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of a diagnosis of cystic fibrosis with at least one F508del mutation or has a mutation that is responsive to the drug confirmed using an FDA-cleared cystic fibrosis mutation test. Renewal: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# AMBRISENTAN

---

## Products Affected

- Ambrisentan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Documentation of WHO Class II-IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ANZUPGO

---

## Products Affected

- Anzupgo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of hand eczema persisting for longer than 3 months, or recurring at least 2 times within 12-month time frame.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Inadequate response, intolerance, or contraindication to at least one moderate to high potency topical corticosteroid, OR documentation showing that topical corticosteroids are not advisable.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# APOMORPHINE

## Products Affected

- Apomorphine Hydrochloride INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: Documentation that the patient's off time has been reduced with apomorphine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Initial: Documentation of failure of maximum tolerable doses of oral levodopa/carbidopa and one of the following: selegiline, ropinirole, pramipexole, entacapone and Ongentys (requires step therapy).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# APREPITANT

---

## Products Affected

- Aprepitant
- Emend SUSR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concomitant use of pimozide.
<b>Required Medical Information</b>	1) Prophylaxis of post operative nausea and vomiting (PONV): confirmation of diagnosis and use as prophylaxis and not for established nausea and vomiting. 2) Prophylaxis of chemotherapy-induced nausea and vomiting: documentation that aprepitant will be prescribed with concurrent IV or oral ondansetron or granisetron or palonosetron and dexamethasone.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	PONV: one month. Prophylaxis of chemotherapy-induced nausea and vomiting: 12 months.
<b>Other Criteria</b>	Part B versus D determination will be made to determine coverage.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# AQNEURSA

---

## Products Affected

- Aqneursa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: a) confirmation of a diagnosis of Niemann-Pick disease type C (NPC) by genetic testing, b) documentation of neurologic symptoms due to NPC, and c) documentation of weight at least 15kg.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist or neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ARALAST

## Products Affected

- Aralast Np INJ 1000MG, 500MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) documented ZZ or Z/null AAT deficiency and 2) AAT serum level less than or equal to 11 micromoles/L or 50mg/dL and 3) moderate emphysema and/or FEV1 less than 80% and 4) the provider has outlined specific, measurable treatment goals such as slowing of FEV1 decline or lack of disease progression. Renewal: documentation patient is meeting treatment goals such as slowing FEV1 decline or lack of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ARCALYST

## Products Affected

- Arcalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Deficiency of Interleukin-1 Receptor Antagonist (DIRA) renewal: documentation of positive clinical response, such as low disease activity or improvement in signs and symptoms. 2) Recurrent pericarditis, renewal: documentation that pericarditis has not recurred. 3) Cryopyrin associated periodic syndrome, renewal: documentation of positive clinical response, such as a reduction in joint pain, resolution of rash, improvement in fatigue.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: an immunologist or a geneticist for DIRA, or a cardiologist for recurrent pericarditis.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For Deficiency of Interleukin-1 Receptor Antagonist (DIRA): failure of Kineret (requires PA).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ARIKAYCE

---

## Products Affected

- Arikayce

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation that Arikayce will be used as part of combination antibacterial drug regimen, and either positive sputum culture or lack of clinical signs of improvement (such as anemia, fever, or lack of reduction in nodule size).
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, HIV specialist or pulmonologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Failure of at least 6 consecutive months of a multidrug regimen (such as combination of the following agents: azithromycin or clarithromycin, ethambutol, rifabutin, clofazimine).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ARISTADA

---

## Products Affected

- Aristada
- Aristada Initio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug: documentation that the patient is currently taking oral Abilify and prescriber wishes to switch to the injection to improve compliance.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ARMODAFINIL

---

## Products Affected

- Armodafinil

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ASTAGRAF

---

## Products Affected

- Astagraf XL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	To prevent or treat an organ transplant rejection, Part B versus D determination will be made to determine coverage. If the drug is to be covered by Part D and the patient is newly started on Astagraf, failure of tacrolimus immediate release or reason why tacrolimus immediate release cannot be used is required.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ATTRUBY

---

## Products Affected

- Attruby

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation confirming the diagnosis of either wild-type or hereditary transthyretin amyloid cardiomyopathy (ATTRwt-CM or hATTR-CM).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# AUSTEDO

## Products Affected

- Austedo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Excluded in patients with suicidality, hepatic impairment, inadequately treated depression, concomitant use of MAOIs and reserpine.
<b>Required Medical Information</b>	Renewal criteria: 1) For Huntington's disease (HD): medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, and increase in quality of life. 2) For tardive dyskinesia (TD): medical record documentation of treatment response such as a reduction in the AIMS score from baseline, improvement in involuntary movement, or improvement in functional ability
<b>Age Restrictions</b>	For tardive dyskinesia (TD): 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: neurologist for HD, neurologist, movement disorder specialist or a psychiatrist for TD.
<b>Coverage Duration</b>	HD Initial: 6 months. TD Initial: 6 months. Renewal for HD and TD: 12 months.
<b>Other Criteria</b>	Initial criteria for HD: failure of or contraindication to tetrabenazine (requires prior authorization). Initial criteria for TD: failure of or contraindication to tetrabenazine and Ingrezza (both require prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# AUVELITY

---

## Products Affected

- Auvelity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on Auvelity: medical record documentation of trial of, intolerance to or contraindication to: a) bupropion and b) an SSRI or SNRI such as sertraline, fluoxetine, escitalopram, paroxetine, venlafaxine, or duloxetine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# BEMPEDOIC ACID

## Products Affected

- Nexletol
- Nexlizet

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Primary hyperlipidemia, initial: documentation of LDL-C greater than 100 mg/dL without cardiovascular disease, or greater than 55 mg/dL with cardiovascular disease. Primary hyperlipidemia, renewal: a) continued treatment with statins unless intolerant or contraindicated, and 2) LDL reduction from baseline. 2) For reducing cardiovascular (CV) event risk, initial: documentation of statin intolerance AND one of the following a) existing cardiovascular disease such as coronary artery disease, symptomatic peripheral arterial disease, and/or cerebrovascular atherosclerotic disease, OR b) high risk of a cardiovascular event.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
<b>Coverage Duration</b>	Primary hyperlipidemia: Initial: 6 months, Renewal: lifetime. Reducing CV event risk: lifetime.
<b>Other Criteria</b>	For all indications, initial: 1) Medical record documentation of failure of, significant side effect from, contraindication, or intolerance to one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis. 2) Failure of Repatha or Praluent. Both require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# BENLYSTA

## Products Affected

- Benlysta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Severe active CNS lupus or used in combination with other biologics or IV cyclophosphamide
<b>Required Medical Information</b>	1) Systemic lupus erythematosus initial criteria: a) Medical record documentation of a diagnosis of systemic lupus erythematosus (SLE) and is auto-antibody positive as defined as Antinuclear antibody (ANA titer) greater than or equal to 1:80 or anti-double stranded DNA antibody (Anti-dsDNA) greater than or equal to 30 IU/ml. b) Receiving standard therapy including NSAIDs, antimalarials, corticosteroids or immunosuppressants. Renewal criteria: medical record documentation of treatment response such as an improvement in the SELENA-SLEDAI score or no worsening of disease activity. 2) Active lupus nephritis initial criteria: a) Medical record documentation of a diagnosis of active lupus nephritis. b) Receiving standard therapy including corticosteroids or immunosuppressants. Renewal: medical record documentation of treatment response such as stabilization of eGFR or no worsening of disease activity.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist or nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# BENZNIDAZOLE

---

## Products Affected

- Benznidazole

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of Chagas disease caused by T. cruzi confirmed by detection of T. cruzi trypomastigotes on microscopy, detection of T. cruzi DNA by PCR assay, or 2 positive diagnostic serologic tests using two different techniques and antigens showing IgG antibodies to T. cruzi.
<b>Age Restrictions</b>	Between 2 years and 12 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or cardiologist.
<b>Coverage Duration</b>	60 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# BEXSERO

---

## Products Affected

- Bexsero INJ 0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Between 10 years and 25 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# BOSENTAN

---

## Products Affected

- Bosentan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Concomitant administration with cyclosporine A or glyburide. 2) Pregnancy.
<b>Required Medical Information</b>	Documentation of New York Heart Association (NYHA) Class II-IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following does not apply to pediatric members with idiopathic/congenital pulmonary arterial hypertension: Failure of or contraindication to sildenafil or tadalafil (both require prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# BOTULINUM TOXINS

## Products Affected

- Botox
- Xeomin

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Chronic migraine (For Botox only): a) Initial: at least 15 days of headache lasting 4 hours a day or longer. b) Renewal: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine. 2. Urinary incontinence (For Botox only) renewal criteria: documentation of treatment response including a decrease in the number of incontinence episodes or frequency. 3. Chronic sialorrhea: Renewal criteria (For Xeomin only): documentation of treatment response such as an improvement in drooling severity, drooling frequency, or improvement in the Global Impression of Change Scale. 4) Renewal criteria for all other diagnoses: documentation of treatment response including a decrease in the severity of dystonia, decrease in pain, or decrease in disability.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Xeomin (chronic sialorrhea): 12 months, 3 dose series. All other diagnoses: 12 months, 4 dose series
<b>Other Criteria</b>	1) Migraine prophylaxis (For Botox only): failure of propranolol and topiramate. 2) Urinary incontinence (For Botox only): failure of two oral anticholinergics such as oxybutynin, tolterodine, or solifenacin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# BRINSUPRI

---

## Products Affected

- Brinsupri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: confirmation of a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by CT scan. Renewal: medical record documentation of clinical benefit, such as reduction in exacerbations, fatigue, malaise or breathlessness, or improved exercise tolerance.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# BRIVIACT

## Products Affected

- Briviact

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on Briviact tablets or suspension. For tabs: medical record documentation of failure of 1) levetiracetam and 2) one of the following: carbamazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, oxcarbazepine, lacosamide, or zonisamide. For suspension: 1) medical record documentation of failure of a) levetiracetam suspension and b) one of the following suspensions or solutions: carbamazepine, phenytoin, felbamate, oxcarbazepine, gabapentin, or lacosamide, and 2) inability to swallow oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# BRONCHITOL

---

## Products Affected

- Bronchitol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Failure of bronchitol tolerance test.
<b>Required Medical Information</b>	Initial: confirmation of a diagnosis of cystic fibrosis.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# BUPRENORPHINE PATCH

---

## Products Affected

- Buprenorphine PTWK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of morphine sulfate ER.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CABLIVI

## Products Affected

- Cablivi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Medical record support of a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP). 2) Documentation that Cablivi will be used in combination with plasma exchange. Renewal: Documented signs of persistent underlying disease such as suppressed ADAMTS13 activity levels remain present.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist.
<b>Coverage Duration</b>	Initial: 90 days. Renewal-receiving plasma exchange: 90 days. Renewal-post plasma exchange: 58 days.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CAMZYOS

## Products Affected

- Camzyos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) medical record documentation of NYHA class II or III obstructive hypertrophic cardiomyopathy and 2) documentation of left ventricular ejection fraction of greater than or equal to 55%. Renewal: 1) documentation of left ventricular ejection fraction of greater than 50% and 2) improvement in symptoms or functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CANCER DRUGS

---

## Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega
- Abraxane
- Akeega
- Alecensa
- Aliqopa
- Alunbrig
- Augtyro
- Avastin
- Avmapki Fakzynja Co-pack
- Ayvakit
- Balversa
- Bavencio
- Beleodaq
- Bendamustine Hydrochloride INJ 100MG, 25MG
- Besremi
- Bexarotene
- Bortezomib INJ 3.5MG
- Bosulif
- Braftovi CAPS 75MG
- Brukinsa
- Busulfan
- Cabometyx
- Calquence TABS
- Caprelsa
- Carmustine INJ 100MG
- Clofarabine
- Cometriq
- Copiktra
- Cotellic
- Cyramza
- Dactinomycin
- Danziten
- Darzalex
- Darzalex Faspro
- Dasatinib
- Daurismo
- Docetaxel INJ 160MG/16ML, 160MG/8ML, 20MG/2ML, 20MG/ML, 80MG/4ML, 80MG/8ML
- Empliciti
- Ensacove

- Erbitux
- Eribulin Mesylate
- Erivedge
- Erleada
- Erlotinib Hydrochloride TABS
- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Everolimus TBSO
- Exkivity
- Firmagon INJ 120MG/VIAL, 80MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Folutyn
- Fotivda
- Fruzaqla
- Fulvestrant
- Gavreto
- Gefitinib
- Gilotrif
- Gomekli
- Hernexeos
- Hyrnuo
- Ibrance
- Iclusig
- Idarubicin Hcl
- Idarubicin Hydrochloride
- Idhifa
- Imatinib Mesylate TABS
- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 280MG, 420MG
- Imfinzi
- Inluriyo
- Inlyta
- Inqovi
- Itovebi
- Iwilfin
- Jakafi
- Jaypirca
- Jevtana
- Keytruda INJ 100MG/4ML
- KISQALI

- KISQALI Femara 200 Dose
- KISQALI Femara 400 Dose
- KISQALI Femara 600 Dose
- KOSELUGO CAPS
- KRAZATI
- KYPROLIS
- LAPATINIB DITOSYLATE
- LAZCLUZE
- LENALIDOMIDE
- LENVIMA 10 Mg Daily Dose
- LENVIMA 12mg Daily Dose
- LENVIMA 14 Mg Daily Dose
- LENVIMA 18 Mg Daily Dose
- LENVIMA 20 Mg Daily Dose
- LENVIMA 24 Mg Daily Dose
- LENVIMA 4 Mg Daily Dose
- LENVIMA 8 Mg Daily Dose
- LIBTAYO
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA TABS
- LYTGABI
- MEKINIST
- MEKTOVI
- MELPHALAN Hydrochloride
- MITOMYCIN INJ 20MG, 40MG, 5MG
- MODEYSO
- MUTAMYCIN
- MYLOTARG
- NELARABINE
- NILOTINIB Hydrochloride
- NINLARO
- NIPENT
- NUBEQA
- ODOMZO
- OGSIVEO
- OJEMDA
- OJJAARA
- ONUREG
- OPDIVO
- ORSERDU

- Paclitaxel Protein-bound Particles INJ 900MG; 100MG
- Pazopanib Hydrochloride
- Pemazyre
- Pemetrexed INJ 100MG, 500MG
- Pemetrexed Disodium
- Perjeta
- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose
- Pomalidomide
- Pralatrexate
- Proleukin
- Qinlock
- Retevmo TABS
- Revuforj
- Rezlidhia
- Romidepsin INJ 10MG
- Romvimza
- Rozlytrek CAPS
- Rubraca
- Rydapt
- Scemblix
- Sorafenib
- Sorafenib Tosylate TABS
- Stivarga
- Sunitinib Malate
- Tabrecta
- Tafenlar
- Tagrisso
- Talzenna
- Tazverik
- Tecentriq
- Tecentriq Hybreza
- Temsirolimus
- Tepmetko
- Tevimbra
- Thiotepa INJ 15MG
- Tibsovo
- Toremifene Citrate
- Trelstar Mixject
- Tretinoin CAPS
- Truqap

- Tukysa
- Turalio CAPS 125MG
- Valchlor
- Vanflyta
- Vectibix INJ 100MG/5ML,  
400MG/20ML
- Venclexta
- Venclexta Starting Pack
- Verzenio
- Vitrakvi
- Vizimpro
- Vonjo
- Voranigo
- Vyxeos
- Welireg
- Xalkori
- Xospata
- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly
- Xtandi
- Yervoy
- Yondelis
- Yonsa
- Zaltrap
- Zanosar
- Zejula TABS
- Zelboraf
- Zolinza
- Zydelig
- Zykadia TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, hematologist, endocrinologist or neurologist. For chronic graft versus host disease, a transplant specialist. For systemic mast cell disease, an allergist or immunologist. For dermatofibrosarcoma protuberans, a dermatologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CAPLYTA

## Products Affected

- Caplyta

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For treatment of schizophrenia: failure of two of the following: lurasidone, Rexulti, Vraylar, Fanapt (requires step therapy for new starts). 2) For treatment of depressive episodes associated with bipolar I or II disorder (bipolar depression): failure of two of the following: lithium, divalproex sodium, lurasidone, quetiapine or olanzapine. 3) For adjunctive therapy with antidepressants for the treatment of major depressive disorder: failure of aripiprazole or quetiapine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CARBAGLU

## Products Affected

- Carglumic Acid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	A) For hyperammonemia type III, Initial: 1) Diagnosis confirmed by DNA testing and 2) Objective, measurable treatment goals are provided. B) For hyperammonemia due to propionic acidemia or methylmalonic acidemia, Initial: medical record documentation of the diagnosis. Renewal for all indications: Medical record documentation of stabilization of disease progression such as stabilization of neurologic impairments or seizures.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CAYSTON

---

## Products Affected

- Cayston

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of 1) FEV1 between 25% and 90% predicted and 2) Pseudomonas aeruginosa infection.
<b>Age Restrictions</b>	7 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or infectious disease specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of failure of or resistance to tobramycin (TOBI).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CERDELGA

---

## Products Affected

- Cerdelga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Diagnostic confirmation by one of the following: a) biochemical assay showing decreased glucocerebrosidase activity in white blood cells or skin fibroblasts or b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene, and 2) Signs and symptoms that are severe enough to result in one or more of the following conditions: moderate-to-severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly, and 3) Documentation from a FDA-cleared test that the patient is an extensive, intermediate or poor CYP2D6 metabolizer and 4) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as 1) Improvement in hematologic markers, such as increased hemoglobin, hematocrit, or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For CYP2D6 extensive and intermediate metabolizers, the dose should not exceed 84mg twice daily. For CYP2D6 poor metabolizers, the dose should not exceed 84mg daily.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CEREZYME

## Products Affected

- Cerezyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Diagnostic confirmation by one of the following: a) biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity or b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene, and 2) Signs and symptoms that are severe enough to result in one or more of the following conditions: moderate-to-severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly, and 3) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as 1) Improvement in hematologic markers, such as increased Hgb/Hct and/or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label. Dose range: 2.5/kg IV 3 times weekly to 60 units/kg IV every 2 weeks. Usual dosage is 60 units/kg IV every 2 weeks.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CHENODAL

---

## Products Affected

- Chenodal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation that the patient is not a candidate for laparoscopic cholecystectomy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of ursodiol.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CHOLBAM

## Products Affected

- Cholbam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Bile acid synthesis defect, initial: medical record documentation of a bile acid synthesis disorder. First renewal after 4 months of initiating treatment: medical record documentation of liver function improvement and lack of complete biliary obstruction. Ongoing renewal criteria: lack of complete biliary obstruction. 2) Peroxisomal disorders, initial: Medical record documentation that Cholbam will be used adjunctively, and that there are liver disease manifestations, steatorrhea, or complications due to decreased absorption of fat soluble vitamins. First renewal after 4 months of initiating treatment: medical record documentation of liver function improvement and lack of complete biliary obstruction. Ongoing renewal criteria: lack of complete biliary obstruction.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist or gastroenterologist.
<b>Coverage Duration</b>	Initial: 4 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CIMZIA

---

## **Products Affected**

- Cimzia
- Cimzia Starter Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Crohn's Disease (CD) initial: moderate to severe disease activity. CD renewal: medical record documentation of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 4) polyarticular juvenile idiopathic arthritis (pJIA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 7) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD, rheumatologist for AS, nr-axSpA, pJIA, RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS initial: failure of or contraindication to two of the following: adalimumab, Enbrel, Simponi, Cosentyx, or Xeljanz. All require prior authorization. Active nr-axSpA initial: failure of two of the following: adalimumab, Cosentyx, Rinvoq. All require prior authorization. CD initial: failure of two of the following: adalimumab, ustekinumab, Skyrizi, Rinvoq. pJIA initial: Failure of or contraindication to two of the following: adalimumab, Orencia. PsA initial: failure of or contraindication to two of the following: adalimumab, Enbrel, Simponi, Orencia, Otezla, Cosentyx, Skyrizi, ustekinumab, Rinvoq, or Xeljanz (IR or XR). PsO initial: failure of or contraindication to two of the following: adalimumab, Enbrel, ustekinumab, Otezla, Cosentyx, Skyrizi. RA initial: failure of or contraindication to two of the following: adalimumab,

	Enbrel, Simponi, Actemra, Orencia, Rinvoq, or Xeljanz (IR or XR). All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CITALOPRAM 40MG

---

**Products Affected**

- Citalopram Hydrobromide TABS 40MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Not covered for members age 60 years or older who newly start on citalopram and using more than 20mg of citalopram per day.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Prior Authorization applies to members who newly start on citalopram and are 60 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CLOBAZAM

---

## Products Affected

- Clobazam SUSP 2.5MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# COBENFY

---

## Products Affected

- Cobenfy
- Cobenfy Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of schizophrenia.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug. Failure of two of the following: lurasidone, aripiprazole, risperidone, olanzapine, quetiapine, ziprasidone.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# COLONY STIMULATING FACTORS

---

## Products Affected

- Fulphila
- Granix INJ 300MCG/0.5ML, 300MCG/ML, 480MCG/0.8ML
- Leukine INJ 250MCG
- Neulasta INJ 6MG/0.6ML
- Stimufend
- Udenyca
- Udenyca Onbody
- Zarxio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	1) AIDS Neutropenia (Leukine) and 2) Myelodysplastic Syndromes (Leukine)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of one the following: a) receiving myelosuppressive chemotherapy for a non-myeloid malignancy, receiving chemotherapy for AML, post-induction chemotherapy for AML (Leukine and Zarxio only), or acute exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome) (for Neulasta, Leukine, Stimufend, Udenyca, and Zarxio only), or b) BMT (allogeneic or autologous) or c) autologous peripheral blood progenitor cell (PBPC) transplant or d) severe chronic neutropenia and not on interferon-ribavirin based Hepatitis C treatment or e) AIDS, or f) myelodysplastic syndromes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CORLANOR

## Products Affected

- Corlanor SOLN
- Ivabradine Hydrochloride

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Adults with chronic heart failure: medical record documentation of the following: 1) Ejection fraction of 35% or less and 2) In sinus rhythm with a resting heart rate of at least 70 beats per minute.
<b>Age Restrictions</b>	Stable symptomatic heart failure due to dilated cardiomyopathy (DCM): between 6 months and 19 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) Receiving maximally tolerated doses of a beta blocker or there is a medical reason why a beta blocker cannot be used and 2) failure of a) an angiotensin receptor enzyme inhibitor or angiotensin receptor blocker or b) a mineralcorticoid receptor antagonist. 3) For oral solution only: Documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CORTROPHIN

---

## **Products Affected**

- Cortrophin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Use of corticotropin intravenously. Corticotropin should not be used in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or active peptic ulcer disease, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin. Corticotropin is contraindicated in patients under the age of 2 with suspected congenital infections and for patients who also have adrenocortical insufficiency or adrenocortical hyperfunction.
<b>Required Medical Information</b>	Medical record documentation of one of the following conditions: 1) Infantile spasms, 2) Acute exacerbation of multiple sclerosis, 3) Exacerbation of rheumatic disorders including psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, or acute gouty arthritis, 4) Exacerbation of or maintenance for collagen diseases including systemic lupus erythematosus, systemic dermatomyositis, 5) Dermatologic diseases including severe erythema multiforme, Stevens-Johnson Syndrome, or severe psoriasis 6) Allergic states such as serum sickness or atopic dermatitis, 7) Ophthalmic diseases including keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, 7) Respiratory diseases such as symptomatic sarcoidosis or 8) Edematous condition from nephrotic syndrome or lupus erythematosus.
<b>Age Restrictions</b>	For infantile spasms: age less than 2 years.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Infantile spasms: until two years of age. All others: 1 month.
<b>Other Criteria</b>	For steroid responsive conditions, conditions number 2 to 7 listed in the Required Medical Information section: medical record documentation of failure of corticosteroid therapy in the last 30 days or reason why corticosteroids cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# COSENTYX

---

## **Products Affected**

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Enthesitis-related arthritis (ERA) renewal: improved functioning and/or signs and symptoms of ERA. 4) Hidradenitis suppurativa (HS): initial: moderate to severe disease evident by documentation of Hurley Stage II or III and at least 3 abscesses or inflammatory nodules. HS renewal: reduction in nodules and abscesses. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, nr-axSpA, ERA, RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS, nr-axSpA and active ERA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CRENESSITY

---

## Products Affected

- Crenessity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Medical record and lab result confirmation of a diagnosis of classic congenital adrenal hyperplasia caused by 21-hydroxylase deficiency. 2) Documentation that Crenessity will be used in combination with supraphysiologic glucocorticoid replacement. Renewal: Documentation of a reduction in daily glucocorticoid replacement dose.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For oral solution only: documentation of an inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CRESEMBA

---

## Products Affected

- Cresemba

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For the treatment of invasive aspergillosis (not required for invasive mucormycosis): failure of voriconazole.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CRISABOROLE

## Products Affected

- Eucrisa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: documentation of mild to moderate atopic dermatitis. Renewal: documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist or dermatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For the treatment of atopic dermatitis if two years and older, initial: failure of 1) tacrolimus ointment or pimecrolimus ointment (requires prior authorization) and 2) if older than 12 years of age: a high potency steroid such as clobetasol.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CTEXTLI

## Products Affected

- Ctextli

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of a diagnosis of cerebrotendinous xanthomatosis (CTX) confirmed via either a) serum cholestanol and/or urine bile alcohol levels or b) genetic testing. Renewal: medical record documentation of improvements in the symptoms of CTX (such as reduction in diarrhea, decrease in spasticity or hyperreflexia, improvement in ataxia or dysarthria) or reduction in serum cholestanol levels or bile alcohol levels.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an endocrinologist, geneticist, metabolic specialist, or neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CUVRIOR

---

## Products Affected

- Cuvrior

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Medical record documentation of stable Wilson's disease who are de-coppered and tolerant to penicillamine. 2) Renewal: medical record documentation of clinical benefit from treatment with Cuvrior.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: Failure of or contraindication to penicillamine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# CYSTADANE

---

## Products Affected

- Betaine Anhydrous

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of diagnostic confirmation such as by measurement of plasma and urine homocysteine levels. Renewal: Medical record documentation of stabilization of disease, such as decrease in plasma and urine homocysteine levels, improvement in neurological and neuromuscular function.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# CYSTEAMINE

---

## Products Affected

- Cystadrops
- Cystaran

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of corneal cysteine crystal deposits. Renewal criteria: medical record documentation of a reduction in corneal crystal deposits.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, metabolic disorder specialist, or ophthalmologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DALFAMPRIDINE

---

## Products Affected

- Dalfampridine Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	History of seizure or moderate or severe renal impairment defined as creatinine clearance less than or equal to 50 mL/min.
<b>Required Medical Information</b>	Initial criteria: medical record documentation of 1) Diagnosis of multiple sclerosis, and 2) Prior to initiation of therapy, the patient must have a timed 25-foot walk time to establish a baseline to evaluate treatment response. Renewal criteria: 1) Medical record documentation of an improvement in the timed 25-foot walk time compared to baseline maximum walk speed.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DAWNZERA

## Products Affected

- Dawnzera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of hereditary angioedema Type 1 and II confirmed by genetic testing or complement studies of C4, C1INH antigenic and C1INH functional levels supporting the diagnosis. For hereditary angioedema Type III, documentation of diagnosis confirmed by genetic testing, normal complement studies combined with clinical features of angioedema or family history. Renewal: Documentation of a reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks or clinical documentation of functional improvement.
<b>Age Restrictions</b>	12 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, allergist or immunologist.
<b>Coverage Duration</b>	Long term prevention, initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: failure of, intolerance to, or contraindication to Takhzyro (requires prior authorization). Initial and renewal: not using concurrently with other prophylaxis medications such as Takhzyro, Heagarda, Orladeyo, or Cinryze.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DAYBUE

---

## Products Affected

- Daybue

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record confirmation of a diagnosis of Rett syndrome. Renewal: Medical record documentation of maintenance or improvement of symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DEFLAZACORT

---

## Products Affected

- Deflazacort
- Jaythari
- Kymbee
- Pyquvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of genetic testing confirmation of Duchenne muscular dystrophy. Renewal criteria: documentation of either a) a positive treatment response (e.g. pulmonary function, muscle strength, functional ability, walk tests), or b) slowing of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of or adverse effects to prednisone.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DENGVAXIA

---

## Products Affected

- Dengvaxia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of a laboratory confirmed previous dengue infection. 2) Documentation of residence in an endemic area.
<b>Age Restrictions</b>	Between 9 years and 16 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DIACOMIT

---

## Products Affected

- Diacomit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of Dravet syndrome. 2) Documentation that Diacomit will be taken with clobazam.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: failure of or contraindication to Epidiolex (requires prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DIFICID

---

## Products Affected

- Dificid SUSR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of an infection caused by clostridium difficile.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	10 days
<b>Other Criteria</b>	For oral powder for suspension only: documentation of an inability to swallow oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DOJOLVI

---

## Products Affected

- Dojolvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD). Renewal: Documentation of improved muscle function, exercise tolerance, or health related quality of life.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DOPTelet

## Products Affected

- Doptelet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Chronic immune thrombocytopenia (ITP): Initial criteria: Medical record documentation of platelet count less 30,000 per mm <sup>3</sup> . Renewal criteria: Medical record documentation of maintenance of platelet counts between 30,000 per mm <sup>3</sup> and 150,000 per mm <sup>3</sup> or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) Chronic liver disease with thrombocytopenia: Platelets less than 50k.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, a hematologist, or a surgeon.
<b>Coverage Duration</b>	ITP: Initial 6 weeks, Renewal 24 weeks. Chronic liver disease with thrombocytopenia: 5 days.
<b>Other Criteria</b>	Chronic immune thrombocytopenia: insufficient response to prior treatment with one of the following, a systemic corticosteroid or an immunoglobulin replacement. Chronic liver disease with thrombocytopenia: Documentation of upcoming procedure.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DOPTELET SPRINKLE

---

## Products Affected

- Doptelet Sprinkle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Chronic immune thrombocytopenia (ITP): Initial criteria: Medical record documentation of platelet count less 30,000 per mm <sup>3</sup> . Renewal criteria: Medical record documentation of maintenance of platelet counts between 30,000 per mm <sup>3</sup> and 150,000 per mm <sup>3</sup> or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) Chronic liver disease with thrombocytopenia: Platelets less than 50k.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, a hematologist, or a surgeon.
<b>Coverage Duration</b>	ITP: Initial 6 weeks, Renewal 24 weeks. Chronic liver disease with thrombocytopenia: 5 days.
<b>Other Criteria</b>	Chronic immune thrombocytopenia: insufficient response to prior treatment with one of the following, a systemic corticosteroid or an immunoglobulin replacement. Chronic liver disease with thrombocytopenia: Documentation of upcoming procedure. For all indications: Inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DRIZALMA

---

## Products Affected

- Drizalma Sprinkle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DRONABINOL

---

## Products Affected

- Dronabinol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	The following criteria only applies to the treatment of nausea and vomiting associated with cancer chemotherapy: 1) failure of at least one of the following antiemetics: dimenhydrinate, meclizine, metoclopramide, promethazine, or prochlorperazine and 2) ondansetron.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# DROXIDOPA

---

## Products Affected

- Droxidopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: medical record documentation of treatment response including decrease in lightheadedness, dizziness or falls.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# DUPIXENT

---

## **Products Affected**

- Dupixent INJ 200MG/1.14ML,  
300MG/2ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>1) Atopic dermatitis initial (AD): body surface area involvement = 10% at baseline. AD renewal: medical record documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline. 2) Moderate to severe asthma, initial: a) documentation of eosinophilic phenotype with eosinophil count greater than or equal to 150 cells/mcL OR documentation that chronic oral steroid use is required for asthma control. Moderate to severe asthma, renewal: reduction in oral steroid use or in asthma symptoms. 3) Chronic rhinosinusitis with nasal polyposis (CR) initial: medical record documentation that a) the condition is inadequately controlled and b) that Dupixent will be used as add-on therapy. CR renewal: treatment response such as reduction in steroid use or need for surgery. 4) Eosinophilic type COPD (E-COPD) initial: eosinophil count of at least 300 cells/mcL. E-COPD Renewal: Improvement in symptoms or less exacerbations. 5) Eosinophilic esophagitis (EE) initial: a) documentation of a diagnosis of eosinophilic esophagitis confirmed by symptoms related to esophageal dysfunction and biopsy showing eosinophil-predominant inflammation (such as a peak value of <math>f \geq 15</math> eosinophils per high power field (HPF) or 60 eosinophils per mm<sup>2</sup>. b) weight of at least 15kg. EE renewal: clinical response, such as improvement in dysphagia or histologic remission. 6) Prurigo nodularis (PN), renewal: clinical response such as an improvement in pruritis, a reduction in nodular lesions, or improvement in functioning. 7) Bullous pemphigoid (BP) initial: histopathological confirmation of diagnosis and use in combo with steroids. Renewal: significant improvement such as remission or decrease in lesions. 7) Urticaria initial: symptoms for at least 6 weeks. Renewal: clinical response such as decrease in symptoms.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist, allergist or imunologist for AD, pulmonologist or allergist for asthma or E-COPD, ENT or otolaryngologist for CR, gastroenterologist for EE.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.

<p><b>Other Criteria</b></p>	<p>Atopic dermatitis: For patients 12 years of age or older: 1) failure of one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and 2) failure of tacrolimus ointment, OR documentation that topical prescription therapies are not appropriate or are contraindicated. Moderate to severe asthma, eosinophilic phenotype or oral corticosteroid dependent: trial and failure of an ICS+LABA combo such as fluticasone/vilanterol or fluticasone/salmeterol. Eosinophilic type uncontrolled COPD, initial: exacerbations while on triple therapy with an ICS + LAMA + LABA combo such as Trelegy or Breztri.</p>
<p><b>Prerequisite Therapy Required</b></p>	<p>Criteria DOES require use of a prerequisite Part D drug.</p>

# DUVYZAT

---

## Products Affected

- Duvyzat

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: genetic testing results confirming a diagnosis of Duchenne muscular dystrophy. Renewal criteria: documentation of a slowing of disease progression.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EGRIFTA

## Products Affected

- Egrifta Sv

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, or head irradiation or trauma, 2) malignancy, active (either newly diagnosed or recurrent), malignancies should be inactive and completely treated prior to initiating therapy, 3) Pregnancy, 4) Body mass index less than or equal to 20 kg/m <sup>2</sup> . 5) Not approved for use in patients without HIV infection.
<b>Required Medical Information</b>	Initial criteria: 1) Lipodystrophy defined as a) For men: a waist circumference of greater than or equal to 95 cm or 37.5 inches or a waist-to-hip ratio of greater than or equal to 0.94 and b) For women: a waist circumference of greater than or equal to 94 cm or 37 inches or a waist-to-hip ratio of greater than or equal to 0.88. 2) Currently on anti-retroviral therapy. Renewal criteria: documentation of treatment response such as reduction in visceral adipose tissue as demonstrated from waist circumference or CT scan.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or HIV specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EKTERLY

## Products Affected

- Ekterly

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of hereditary angioedema by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal OR c) Normal C1-INH levels and one of the following: i) Confirmed presence of variant(s) in the gene(s) for FXII (F12), angiotensin-converting enzyme 1 (ACE1), plasminogen (PLG), kininogen-1 (KNG1), myoferlin (MYOF), and heparan sulfate-glucosamine 3-Osulfotransferase 6 (HS3ST6) OR ii) Recurring angioedema attacks that are refractory to high-dose antihistamines. Renewal criteria for long-term prevention: Documentation of a reduction in symptoms such as abdominal pain, cutaneous pain and cutaneous swelling.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, hematologist or immunologist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: Failure of or contraindication to icaltibatant.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ELAPRASE

## Products Affected

- Elaprase

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Diagnostic confirmation of by such as presence of glycosaminoglycans (GAG) in the urine, deficiency in iduronate-2-sulfatase enzyme activity, or genetic testing, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as improvement in percent predicted FVC, improvement in 6-minute walk test, reduction in urinary GAG levels, or reduction in liver or spleen size.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: 0.5mg/kg IV once weekly.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ELIQUIS

---

## Products Affected

- Eliquis CPSP
- Eliquis TBSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of an inability to swallow solid oral dosage forms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ELTROMBOPAG

---

## Products Affected

- Eltrombopag Olamine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Persistent or chronic immune (idiopathic) thrombocytopenic purpura (ITP) initial: medical record documentation of platelet count less 30,000 per mm <sup>3</sup> . ITP Renewal: maintenance of platelet counts between 30,000 per mm <sup>3</sup> and 150,000 per mm <sup>3</sup> or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) thrombocytopenia in patients with chronic Hepatitis C (Hep C thrombocytopenia), initial: a) platelets less than 75,000 per mm <sup>3</sup> . b) request to treat thrombocytopenia to allow initiation of interferon-based therapy. Hep C thrombocytopenia renewal: medical record documentation that platelets have increased since initiating eltrombopag. 3) Aplastic anemia (AA) initial: platelets counts less than or equal to 30,000 per mm <sup>3</sup> . AA renewal: maintenance of platelet counts between 30,000 per mm <sup>3</sup> and 150,000 per mm <sup>3</sup> or an increase in platelet counts from baseline.
<b>Age Restrictions</b>	1 year of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: hematologist or oncologist for AA and ITP, hematologist, hepatologist, gastroenterologist, infectious disease specialist or oncologist for Hep C thrombocytopenia.
<b>Coverage Duration</b>	ITP: Initial 6wk, Renew 6mo. HepC, thrombo: Initial 3mo, Renew 12mo. AA: Initial 4mo, Renew 12mo.
<b>Other Criteria</b>	The following criteria only applies to persistent or chronic immune (idiopathic) thrombocytopenia: documentation of disease refractory to the following: systemic corticosteroids, immunoglobulin replacement or splenectomy. For suspension: documentation of an inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# EMGALITY

## Products Affected

- Emgality

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Episodic cluster headache: 1) Initial: medical record documentation of the diagnosis and that the patient has experienced at least 2 cluster periods from 7 to 365 days, separated by pain free periods lasting at least 3 months. 2) Renewal: documentation of treatment response including a reduction in headaches, decreased abortive medication use, or emergency room visits. 3) Not used in combination with another CGRP inhibitor. Migraines: 1) Initial: episodic migraine, 4-14 headache days per month. Chronic migraines, 15 or more headache days per month with at least 8 days of migraines for 3 months. 2) Renewal: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Documentation that Emgality will not be used with a second CGRP agent for migraine prevention.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EMPAVELI

## Products Affected

- Empaveli

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Paroxysmal nocturnal hemoglobinuria (PNH): medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria confirmed by high-sensitivity flow-cytometry. PNH Renewal: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline. 2) C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN): medical record documentation of the diagnosis confirmed by biopsy, proteinuria greater than or equal to 1 g/day and spot urine protein-to-creatinine ratio greater than or equal to 1 g/g. Renewal: clinical benefit such as reduction in proteinuria.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with a nephrologist, hematologist or an oncologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EMSAM

## Products Affected

- Emsam

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Concomitant use of the any of the following medications: SSRIs, SNRIs, TCAs, MAOIs, sympathomimetic amines including amphetamines, meperidine, tramadol, methadone, mirtazapine, bupropion, cyclobenzaprine, carbamazepine and oxcarbamazepine.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of or intolerance to at least 2 of the following: 1) a selective serotonin receptor reuptake inhibitor such as citalopram, escitalopram, fluoxetine, paroxetine, or sertraline, 2) an SNRI such as venlafaxine or duloxetine, 3) bupropion or 4) mirtazapine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ENBREL

---

## **Products Affected**

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) Renewal: Improved functioning and/or symptoms. 2) Juvenile idiopathic arthritis (JIA) and juvenile psoriatic arthritis (JPsA) renewal: Improved functioning and/or improvement in tender joint count and swollen joint count. 3) Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 5) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, JIA, JPsA, RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS initial: failure of one oral non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA and JPsA initial: failure of methotrexate for at least 8 weeks. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine. RA Initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ENDARAVONE

---

## Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a specialist in Amyotrophic Lateral Sclerosis (ALS).
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ENDARI

---

## Products Affected

- L-glutamine PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: medical record documentation that the drug has been effective in reducing the number of sickle cell crisis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Medical record documentation of failure of or intolerance to hydroxyurea. Failure defined as continued acute complications or pain crisis or continued need for blood transfusions while on hydroxyurea.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ENSPRYNG

---

## Products Affected

- Enspryng

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of anti-aquaporin-4 (AQP4) antibody positive neuromyelitis optica spectrum disorder
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ENTYVIO

## Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	CD initial: Failure of two of the following: adalimumab, ustekinumab, Rinvoq, Simponi, Skyrizi. All require prior authorization. UC Initial: Failure of two of the following: adalimumab, ustekinumab, Rinvoq, Simponi, Skyrizi and Xeljanz. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# EOHILIA

## Products Affected

- Eohilia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of a diagnosis of eosinophilic esophagitis confirmed by symptoms related to esophageal dysfunction and biopsy showing eosinophil-predominant inflammation (such as a peak value of $f \geq 15$ eosinophils per high power field (HPF) or 60 eosinophils per mm <sup>2</sup> . Renewal: documentation of a clinical response, such as improvement in dysphagia or histologic remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EPIDIOLEX

---

## Products Affected

- Epidiolex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For all diagnoses: Epidiolix must be used as adjunctive treatment. 2) For Lennox-Gastaut Syndrome: failure of two of the following: clonazepam, valproate, topiramate, lamotrigine, felbamate or rufinamide.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

## ERYTHROPOIESIS-STIMULATING AGENTS

### Products Affected

- Procrit
- Retacrit

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Anemia associated with chronic kidney disease (CKD): a) Hgb below 10 g/dL or Hct below 30% and b) ferritin at least 100 ng/mL and/or c) transferrin saturation at least 20%. 2) Anemia associated with cancer treatment for non-myeloid cancers: a) Hgb below 10 g/dL or Hct below 30% and b) ferritin at least 100 ng/mL and/or c) transferrin saturation at least 20%. 3) Anemia associated with Zidovudine therapy in HIV/AIDS: a) Hgb below 10 g/dL or Hct below 30% and b) transferrin saturation at least 20%, and c) endogenous erythropoietin below 500 IU/L, 4) Surgery: a) high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery and b) baseline Hgb greater than 10g/dL, but below 13g/dL. Renewal criteria for 1-3: transferrin saturation greater than 20%.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CKD and HIV: 12 months. Cancer: 6 months. Surgery: 1 month.
<b>Other Criteria</b>	1) Anemia associated with zidovudine therapy: zidovudine dose less than 4200mg per week verified by claim history. 2) For end stage renal disease (ESRD) patients on dialysis, Part B versus Part D determination will be made to determine if the drug prescribed will be used for an ESRD-related condition. For ESRD-related conditions, the drug will be covered under Part B and provided by the dialysis center.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ESLICARBAZEPINE

---

## Products Affected

- Eslicarbazepine Acetate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of 1) oxcarbazepine and 2) One of the following: carbamazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, lacosamide, levetiracetam.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# EVENTITY

## Products Affected

- Eventity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Stroke or myocardial infarction in the last 12 months. 2) Uncorrected hypocalcemia.
<b>Required Medical Information</b>	Medical record documentation of high risk or very high risk of fracture defined as a history of osteoporotic fracture, or multiple risk factors for fracture (such as bone mineral density less than -2.5, previous minimal trauma fracture as an adult, low weight or body mass index, history of hip fracture in a first degree relative, tall stature or use of tobacco). Very high risk of fracture is defined as recent fracture (within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm such as long term steroids, very low T-score such as less than -3, high risk of falls or history of injurious falls, and very high fracture probability determined by the Fracture Risk Assessment Tool (FRAX).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months maximum. Use is not recommended for longer.
<b>Other Criteria</b>	The following criteria do not apply if considered very high risk for fracture: Failure of or contraindication to 1) oral bisphosphonates and 2) Prolia.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# EVRYSDI

---

## Products Affected

- Evrysdi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record confirmation of a diagnosis of spinal muscle atrophy (SMA) confirmed by genetic testing.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EXONDYS

## Products Affected

- Exondys 51

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of a confirmed mutation of the Duchenne muscular dystrophy (DMD) gene that is amenable to exon 51 skipping. Renewal criteria: Documentation of an improvement in symptoms including distance that a patient can walk on a flat, hard surface in a period of 6 minutes and/or reduction in disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# EXXUA

---

## Products Affected

- Exxua
- Exxua Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Prolonged QTc interval greater than 450msec at baseline. 2) Congenital long QT syndrome. 3) Concomitant use of strong CYP3A4 inhibitors. 4) Severe hepatic impairment. 5) Use with an MAOI or within 14 days of stopping treatment with EXXUA.
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of major depressive disorder.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to new starts only. Initial: failure of two of the following: fluoxetine, sertraline, citalopram, escitalopram, paroxetine, venlafaxine, desvenlafaxine
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FABHALTA

## Products Affected

- Fabhalta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Paroxysmal nocturnal hemoglobinuria (PNH): medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria. PNH Renewal: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline. 2) Primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN. b) laboratory results confirming proteinuria. IgAN renewal: medical record documentation of clinical benefit, such as a decrease in urine protein-to-creatinine ratio from baseline. 3) C3 glomerulopathy (C3G): medical record documentation of the diagnosis confirmed by biopsy and spot urine protein-to-creatinine ratio greater than or equal to 1 g/g. Renewal: clinical benefit such as reduction in proteinuria.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: hematologist or oncologist for PNH, nephrologist for IgAN.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	IgAN: documentation of failure of or contraindication to Filspari (requires prior authorization) OR Vanrafia (requires prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FABRAZYME

## Products Affected

- Fabrazyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) For males, diagnostic confirmation of a-galactosidase levels (a- GAL) of less than 1.5 nmol/hr/ml on plasma or less than 4nmol/hr/mg in leukocytes. For females, diagnostic confirmation based on low leukocyte a- GAL A or family history of genetic mutation analysis of the a- GAL A gene or characteristic findings e.g., angiokeratomas, telangiectasias, severe neuropathic pain and organ involvement, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization or slowing of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: 1 mg/kg IV infusion every 2 weeks.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# FASENRA

## Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Asthma initial criteria: 1) Medical record documentation of a diagnosis of severe asthma with eosinophilic phenotype and 2) Blood eosinophil levels greater than or equal to 150 cells/mcL in the last 4 weeks. Asthma renewal criteria: documentation of or claims history showing a reduction in the use of oral steroids or reduction in asthma symptoms. Eosinophilic granulomatosis with polyangiitis (EGPA) initial: 1) diagnosis confirmed by documentation of asthma, and 2) blood eosinophil level of 10% or an absolute count of greater than 1000 cells/mm <sup>3</sup> . EGPA renewal criteria: documentation of response to treatment such as achievement of remission, decrease in the use of steroids, decrease in the rate of relapses or improvement in asthma symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for asthma, rheumatologist, pulmonologist, immunologist or vasculitis specialist for EGPA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Asthma, initial: failure of an inhaled corticosteroid and a long-acting beta agonist.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FETZIMA

---

## Products Affected

- Fetzima
- Fetzima Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of 1) an SSRI such as sertraline or fluoxetine and 2) an SNRI such as venlafaxine and or duloxetine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FIDAXOMICIN

---

## Products Affected

- Fidaxomicin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of an infection caused by clostridium difficile.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	10 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FILSPARI

---

## Products Affected

- Filspari

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Immunoglobulin A nephropathy initial: 1) medical record documentation of biopsy confirmed primary immunoglobulin A nephropathy. Renewal: medical record documentation of a decrease in urine protein-to-creatinine ratio from baseline.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# FILSUVEZ

---

## Products Affected

- Filsuvez

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of genetic testing confirmation of junctional epidermolysis bullosa (JEB) or dystrophic epidermolysis bullosa (DEB). Renewal: medical record documentation of clinical response (i.e. wound healing).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist or wound care specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# FINGOLIMOD

## Products Affected

- Fingolimod Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Unstable angina, transient ischemic attack, myocardial infarction, stroke, heart failure Class III/IV or decompensated heart failure requiring hospitalization within the last 6 months. 2) Concomitant Class Ia or Class III anti-arrhythmic drugs. 3) Mobitz type II second-degree, third-degree atrioventricular block, sick-sinus syndrome unless the patient has a functional pacemaker. 4) QTc interval at baseline 500 milliseconds or greater.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation that fingolimod is being requested for monotherapy and is not intended to be used in combination with other disease modifying multiple sclerosis agents.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# FINTEPLA

---

## Products Affected

- Fintepla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of or contraindication to Epidiolex (requires PA for new starts).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# FIRDAPSE

---

## Products Affected

- Firdapse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	History of seizure
<b>Required Medical Information</b>	Initial: Confirmation of a diagnosis of Lambert-Eaton myasthenic syndrome via EMG or antibody testing. Renewal: Documentation of a treatment response such as a reduction in muscle weakness or functional impairment.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# GALAFOLD

## Products Affected

- Galafold

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) For males, diagnostic confirmation of a-galactosidase levels (a- GAL) of less than 1.5 nmol/hr/ml on plasma or less than 4nmol/hr/mg in leukocytes. For females, diagnostic confirmation based on low leukocyte a- GAL A or family history of genetic mutation analysis of the a- GAL A gene or characteristic findings e.g., angiokeratomas, telangiectasias, severe neuropathic pain and organ involvement, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization or slowing of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# GARDASIL

---

## Products Affected

- Gardasil 9 INJ 0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Between 9 years and 45 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# GATTEX

---

## Products Affected

- Gattex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation that the patient is dependent on parenteral support. Renewal criteria: Medical record documentation of a decrease in parenteral support such as a decrease in volume and/or frequency.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# GEMTESA

---

## Products Affected

- Gemtesa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: for overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adult males on pharmacological therapy for benign prostatic hyperplasia (BPH), documentation that the member is receiving pharmacological therapy for BPH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria does not apply to adult males with BPH: Failure of mirabegron.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# GLYCEROL PHENYLBUTYRATE

---

## Products Affected

- Glycerol Phenylbutyrate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of urea cycle disorder confirmed by DNA testing. Renewal: Medical record documentation of stabilization of disease progression such as stabilization of neurologic impairments or seizures.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Failure of sodium phenylbutyrate powder (requires prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# GRANISETRON

## Products Affected

- Granisetron Hcl INJ 1MG/ML
- Granisetron Hydrochloride

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prevention or treatment of nausea and vomiting associated with cancer chemotherapy or radiation: documentation of current treatment with 1) moderately or highly emetogenic chemotherapy or 2) total body, upper hemi-body or abdominal irradiation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Nausea and vomiting, cancer treatment: 12 months. Post-operative nausea and vomiting: one month.
<b>Other Criteria</b>	1) Not receiving concurrent oral or IV ondansetron, Kytril, Anzemet or Emend. 2) If granisetron is being used as part of a cancer chemotherapy regimen, Part B versus D determination will be made to determine coverage.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# HAEGARDA

## Products Affected

- Haegarda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Documentation of hereditary angioedema Type 1 and II confirmed by genetic testing or complement studies of C4, C1INH antigenic and C1INH functional levels supporting the diagnosis. 2) For hereditary angioedema Type III, documentation of diagnosis confirmed by genetic testing, normal complement studies combined with clinical features of angioedema or family history. Renewal criteria for long term prevention: Documentation of a reduction in the number of angioedema attacks, improvement in the severity and duration of attacks or clinical documentation of functional improvement.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, hematologist or immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# HETLIOZ

## Products Affected

- Hetlloz Lq
- Tasimelton

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	A) Non-24 hour sleep-wake cycle, initial: documentation of a diagnosis that meets the International Classification of Sleep Disorders diagnostic criteria. Renewal: documentation of an increase in nighttime sleeping and decrease in daytime napping. B) Dyssomnia due to Smith-Magenis syndrome, initial: medical record documentation of the diagnosis. Renewal: documentation of an improvement in sleep quality.
<b>Age Restrictions</b>	Hetlloz LQ only: between 3 years and 15 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# HYFTOR

---

## Products Affected

- Hyftor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of a confirmation of facial angiofibroma associated with tuberous sclerosis. Renewal: medical record documentation of a clinical response to therapy, such as improvement in size or redness of facial angiofibroma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 12 weeks. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# IBTROZI

## Products Affected

- Ibtrozi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) Failure of, intolerance or contraindication to: a) Xalkori and 2) Rozyltrek. Both require prior authorization. 2) Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ICATIBANT

## Products Affected

- Icatibant Acetate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of hereditary angioedema Type 1 and II confirmed by genetic testing or complement studies of C4, C1INH antigenic and C1INH functional levels supporting the diagnosis. For hereditary angioedema Type III, documentation of diagnosis confirmed by genetic testing, normal complement studies combined with clinical features of angioedema or family history.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, allergist or immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# IMBRUVICA 140MG TABLETS

## Products Affected

- Imbruvica TABS 140MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, hematologist, or transplant specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) Documentation why the 140mg capsules cannot be used. 2) Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# IMKELDI

## Products Affected

- Imkeldi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, or in certain conditions a hematologist, endocrinologist, neurologist, allergist or dermatologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) Documentation of an inability to swallow oral tablets. 2) Drug must be prescribed for an FDA approved indication, or if prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex, or if prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# IMPAVIDO

---

## Products Affected

- Impavido

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record confirmation of a diagnosis of leishmaniasis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	28 days
<b>Other Criteria</b>	Failure of amphotericin B or Ambisome.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# INBRIJA

---

## Products Affected

- Inbrija

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: Documentation that the patient's off time has been reduced with Inbrija.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 month. Renewal: Lifetime.
<b>Other Criteria</b>	Initial: failure of maximum tolerable doses of oral levodopa/carbidopa and one of the following: selegiline, ropinirole, pramipexole, entacapone and Ongentys (requires step therapy).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# INCRELEX

## Products Affected

- Increlex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Evidence of closure of epiphyseal plate. 2) Active or suspected neoplasia.
<b>Required Medical Information</b>	1) Primary IGF-1 Deficiency, Initial: a) Secondary causes have been ruled out, such as growth hormone deficiency, malnutrition, hypothyroidism, and chronic corticosteroid therapy, b) Height standard deviation score less than or equal to -3, c) basal IGF-1 standard deviation score of less than or equal to -3 and d) normal or elevated growth hormone, greater than or equal to 10ng/ml to at least two stimuli including insulin, levodopa, arginine, clonidine, or glucagon. Renewal criteria: documentation of clinical improvement, such as an increase in height velocity. 2) Growth Hormone Gene Deletion Initial: evidence of gene deletion and (+) neutralizing antibodies to growth hormone. Renewal criteria: documentation of clinical improvement, such as an increase in height velocity.
<b>Age Restrictions</b>	Between 2 years and 18 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# **INFLIXIMAB**

---

## **Products Affected**

- Avsola
- Inflectra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Moderate to severe heart failure, doses greater than 5mg/kg should not be administered
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 3) Hidradenitis suppurativa (HS) initial: moderate to severe disease evident by documentation of Hurley Stage II or III and at least 3 abscesses or inflammatory nodules. HS renewal: medical record documentation of a reduction in nodules or abscesses. 4) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of more than 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 7) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 8) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission. 9) Uveitis initial: documentation of non-infectious, intermediate, posterior or panuveitis. Renewal: documentation that treatment response is being monitored for the following development of new inflammatory chorioretinal and/or inflammatory retinal vascular lesions, anterior chamber cell grade or vitreous haze, or visual acuity.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, gastroenterologist for UC and CD, ophthalmologist for uveitis, rheumatologist for AS, JIA, JPsA, RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA initial: failure of an 8 week trial of methotrexate. PsO initial: failure of a) one topical agent such

	as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and b) methotrexate or cyclosporine. RA initial: failure of methotrexate and at least one other DMARD such as leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# INGREZZA

## Products Affected

- Ingrezza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Tardive dyskinesia, renewal: medical record documentation of treatment response such as a reduction in the Abnormal Involuntary Movement Scale (AIMS) score from baseline, improvement in involuntary movement, or improvement in functional ability. Chorea associated with Huntington's disease, renewal: medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, or increase in quality of life.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, movement disorder specialist or a psychiatrist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# INREBIC

## Products Affected

- Inrebic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) Failure of Jakafi or the prescriber must provide a medical reason why Jakafi cannot be used. 2) Drug must be prescribed for an FDA approved indication or a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex if for non-cancer use, or supported by NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, and acceptable medical journals for cancer indication.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# INSULIN ADMINISTRATION SUPPLIES

## Products Affected

- Alcohol Prep Pads PADS 70%
- Bd Autosield Duo 30g X 5mm
- Bd Insulin Syringe Safetyglide/1ml/29g X 1/2"
- B-d Insulin Syringe Ultrafine Ii/0.3ml/31g X 5/16"
- Bd Insulin Syringe Ultra-fine/0.5ml/30g X 12.7mm
- Bd Insulin Syringe Ultra-fine/1ml/31g X 8mm
- Bd Pen Needle/original/ultra-fine/29g X 12.7mm
- Curity Gauze Pads 2"x2" 12 Ply

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of or claims history of insulin use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

# INTRAVENOUS IMMUNE GLOBULIN

---

## Products Affected

- Atgam
- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamastan
- Gammagard Liquid
- Gammagard Liquid Erc
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Privigen
- Thymoglobulin

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	1) HIV, 2) Allogeneic bone marrow transplant (BMT), 3) Pregnancy-associated idiopathic thrombocytopenic pupura, 4) Myasthenia Gravis (MG), 5) Autoimmune Mucocutaneous Blistering Disease (AMBD), 6) Autoimmune Hemolytic Anemia, Warm Type (AHA-W), 7) Polymyositis and 8) Dermatomyositis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Acute Idiopathic Thrombocytopenic Purpura: platelet less than 30,000 or need to increase platelet prior to major, invasive surgery. 2) Chronic ITP: duration of illness less than 6 months, no concurrent illness/disease explaining thrombocytopenia, platelets persistently below 20,000. 3) ITP in pregnancy: previous deliveries of children with autoimmune thrombocytopenia or platelets below 30,000 associated with bleeding before delivery, or platelets below 75,000 during the current pregnancy or history of splenectomy. 4) Chronic B-Cell Lymphocytic Leukemia with hypogammaglobulinemia: IgG below 600 and evidence of specific antibody deficiency and repeated bacterial infections. 5) HIV: CD4+ greater than 200/mm <sup>3</sup> , and clinically symptomatic. 6) BMT: hematologic neoplasm, seropositive for CMV prior to transplant, severe hypogammaglobulinemia defined as IgG less than 400 within the first 100 days post transplant, and seronegative donor. 7) Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) including Guillain-Barre Syndrome: Difficulty with venous access for plasmapheresis, or rapidly progressive form of disease with symptoms less than 2 weeks or deteriorating ability to ambulate, or deteriorating PFTs. 8) Autoimmune Mucocutaneous Blistering Disease (AMBD): Diagnosis of pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid or epidermolysis bullous acquisita. 9) Autoimmune Hemolytic Anemia, Warm Type: Predominance of IgG antibodies or comorbid hepatomegaly or hepatosplenomegaly. 10) Polymyositis and Dermatomyositis: associated with severe disability. 11) Acute Myasthenia Gravis (AMG): a) Myasthenic exacerbation defined by difficulty swallowing, acute respiratory failure, or major functional disability or b) presurgical treatment. 12) Multifocal motor neuropathy (For Gammagard only): medical record documentation of treatment response such as improvement in functional ability such as grip strength.
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Acute ITP, ITP in pregnancy, HIV, BMT, AMBD, AMG, 3 months: All other diagnoses: Lifetime
<b>Other Criteria</b>	1) For primary immunodeficiencies only, IVIG may be covered in the home under Medicare Part B if coverage guidelines are met. 2) Chronic ITP requires failure of prednisone. 3) AMG requires failure of two of the following: pyridostigmine, prednisone, azathioprine, or methotrexate. 4) AMBD requires a) failure of prednisone and at least one of the following: methotrexate, azathioprine, cyclosporine or cyclophosphamide or b) evidence of rapid disease progression and urgent administration of IVIG is medically necessary. 5) Polymyositis and Dermatomyositis require failure of prednisone and at least one of the following: methotrexate, azathioprine, cyclosporine or cyclophosphamide.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# IQIRVO

## Products Affected

- Iqirvo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Confirmation of a diagnosis of primary biliary cholangitis. 2) documentation of an inadequate treatment response to ursodeoxycholic acid (UDCA), or documented contraindication to UDCA. Renewal: 1) documentation of reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist or hepatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# IRON CHELATING AGENTS

---

## Products Affected

- Deferasirox
- Deferiprone
- Ferriprox SOLN

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic iron overload due to blood transfusions (deferiprone and deferasirox) Initial: documentation of elevated sodium ferritin levels. For non-transfusion-dependent thalassemia syndromes (deferasirox only) Initial: 1) liver iron concentrations at least 5 milligrams of iron per gram of liver dry weight and 2) serum ferritin greater than 300 mcg/L. For transfusional iron overload in patients with sickle cell disease or other anemias (deferiprone only), initial: documentation of elevated sodium ferritin levels. Renewal criteria for all indications: reduction in total body iron, evidenced by decreased ferritin levels.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For chronic iron overload due to blood transfusions, Initial: Failure of deferoxamine or reason why deferoxamine cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ISOTRETINOIN

---

## Products Affected

- Accutane
- Amnesteem
- Claravis CAPS 10MG
- Isotretinoin CAPS 10MG, 20MG, 30MG, 40MG
- Zenatane

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Females who are pregnant or who may become pregnant and are not using at least two forms of contraception.
<b>Required Medical Information</b>	Medical record documentation of negative pregnancy test and use of reliable methods of birth control in females of child-bearing age.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	20 weeks
<b>Other Criteria</b>	Documentation of failure of at least a 4 week trial of a) one oral antibiotic (e.g., tetracycline, doxycycline, minocycline, or erythromycin) and b) topical tretinoin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# JOENJA

---

## Products Affected

- Joenja

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Medical record confirmation of a diagnosis of activated phosphoinositide 3-kinase delta (PI3K $\delta$ ) syndrome (APDS). 2) Weight of at least 45kg or greater.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an immunologist, hematologist, oncologist, allergist or geneticist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# JOURNAVX

---

## Products Affected

- Journavx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of moderate to severe acute pain and that treatment is intended to be 14 days or less.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	Failure of, intolerance to, or contraindication to 1) an NSAID, and 2) a short-acting opioid. Short-acting opioids are not required if there is a history or risk of substance use disorder.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# JUXTAPID

## Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: diagnosis of homozygous familial hypercholesterolemia. Renewal criteria: reduction in LDL-C.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Failure of or intolerance to: 1) ezetimibe and 2) rosuvastatin or atorvastatin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# KALYDECO

---

## Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: medical record documentation of a diagnosis of cystic fibrosis with genetic confirmation of a mutation in the CFTR gene that is responsive to Kalydeco (ivacaftor). Renewal criteria: medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# KERENDIA

## Products Affected

- Kerendia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of 1) a) diagnosis of chronic kidney disease associated with type 2 diabetes and b) eGFR of at least 25 mL/min/1.73m <sup>2</sup> or 2) heart failure with left ventricular ejection fraction (LVEF) greater than or equal to 40%.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or a cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Heart failure, initial: failure of, intolerance to, or contraindication to a SGLT-2 inhibitor such as Farxiga.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# KEVEYIS

---

## Products Affected

- Dichlorphenamide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: medical record documentation of a reduction in the number, frequency or duration of paralytic attacks.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# KINERET

## Products Affected

- Kineret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Deficiency of Interleukin-1 Receptor Antagonist (DIRA) renewal: documentation of a positive clinical response, such as low disease activity, or improvement in signs and symptoms. 2) Neonatal onset multi-system inflammatory disease, renewal: improvement in symptoms or laboratory markers. 3) Rheumatoid Arthritis (RA) Renewal: Improved functioning and/or improvement in tender joint count and swollen joint count.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist for RA, rheumatologist, immunologist or geneticist for DIRA.
<b>Coverage Duration</b>	RA Initial: 6 mo. Renewal: 12 mo. Neonatal Onset Multi-system Inflammatory Disease, DIRA: 12 mo.
<b>Other Criteria</b>	RA initial: failure of two of the following: adalimumab, Enbrel, Simponi, Actemra, Orencia, Rinvoq, or Xeljanz (IR or XR). All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# KORLYM

## Products Affected

- Mifepristone TABS 300MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Not covered for use in patients with type 2 diabetes mellitus that is not associated with Cushing's syndrome. 2) Not covered in pregnant females.
<b>Required Medical Information</b>	Initial criteria: Documentation of failure of surgical treatment or the patient is not a candidate for surgery. Renewal criteria: documentation of a reduction in HbA1c or has reached target HbA1c.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# KOSELUGO GRANULE

## Products Affected

- Koselugo CPSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of the diagnosis. 2) Medical record documentation of an inability to swallow solid oral dosage forms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or in certain conditions a hematologist, endocrinologist or neurologist. For chronic graft versus host disease, a transplant specialist. For systemic mast cell disease, an allergist or immunologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LAMPIT

## Products Affected

- Lampit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of Chagas disease caused by T. cruzi confirmed by detection of T. cruzi trypomastigotes on microscopy, detection of T. cruzi DNA by PCR assay, or 2 positive diagnostic serologic tests using two different techniques and antigens showing IgG antibodies to T. cruzi.
<b>Age Restrictions</b>	Between 0 years and 18 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or cardiologist.
<b>Coverage Duration</b>	60 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LANTHANUM

---

## Products Affected

- Fosrenol PACK
- Lanthanum Carbonate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	When the member is receiving dialysis for end stage renal disease, the drug will be covered under Part B and provided by the dialysis center. For those not receiving dialysis: Trial of calcium acetate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

# LEUPROLIDE

## Products Affected

- Eligard
- Leuprolide Acetate INJ 1MG/0.2ML, 22.5MG
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Gender dysphoria (GD)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, oncologist, obstetrician/gynecologist, urologist, or endocrinologist.
<b>Coverage Duration</b>	Anemia due to leiomyoma: 3 mo. EM, CPP, uterine leiomyoma: 6 mo. GD: 12 mo. Cancer: Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LEVOLEUCOVORIN

---

## Products Affected

- Levoleucovorin INJ 50MG
- Levoleucovorin Calcium

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, rheumatologist, or gastroenterologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Medical record documentation of failure of leucovorin or reason why leucovorin cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LIDOCAINE PATCH

---

## Products Affected

- Lidocaine PTCH 5%

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	1) Diabetic peripheral neuropathy, 2) Cancer neuropathic pain, 3) Chronic back pain, 4) Osteoarthritis of hip or knee.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LIRAGLUTIDE

---

## Products Affected

- Liraglutide INJ 6MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LISDEXAMFETAMINE

---

## Products Affected

- Lisdexamphetamine Dimesylate CAPS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Attention deficit hyperactivity disorder only: trial of 1) amphetamine-dextroamphetamine ER capsules or dextroamphetamine ER and 2) methylphenidate ER or dexmethylphenidate ER.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LITHIUM SOLUTION

---

## Products Affected

- Lithium

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria only applies to members who newly start on the drug: Medical record documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LIVDELZI

## Products Affected

- Livdelzi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Confirmation of a diagnosis of primary biliary cholangitis. 2) documentation of an inadequate treatment response to ursodeoxycholic acid (UDCA), or documented contraindication to UDCA. Renewal: 1) documentation of reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist or hepatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LIVMARLI

---

## Products Affected

- Livmarli

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of pruritis associated with Alagille syndrome OR cholestatic pruritis due to progressive familial intrahepatic cholestasis (PFIC). Renewal: Medical record documentation of clinical benefit, such as a decrease in pruritis, or improvement in quality of life.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LIVTENCITY

---

## Products Affected

- Livtency

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of 1) a history of solid organ transplant or hematopoietic stem cell transplantation, and 2) cytomegalovirus infection/disease.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, transplant specialist or oncologist.
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	Failure of valganciclovir, ganciclovir, cidofovir or foscarnet.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LODOCO

---

## Products Affected

- Lodoco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of established atherosclerotic cardiovascular disease or multiple risk factors for cardiovascular disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or lipid specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or intolerance to two statins, such as atorvastatin or rosuvastatin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LUCEMYRA

---

## Products Affected

- Lofexidine Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LUMIZYME

---

## Products Affected

- Lumizyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Clinical symptoms and biochemical testing indicates alpha-1,4-glucosidase deficiency, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: 20 mg/kg IV every 2 wk.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# LUPKYNIS

## Products Affected

- Lupkynis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Receiving standard therapy including corticosteroids and immunosuppressants. Renewal: medical record documentation of 1) treatment response such as stabilization of eGFR or no worsening of disease activity and 2) continued use of background immunosuppressant therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of Benlysta (requires prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# LYBALVI

---

## Products Affected

- Lybalvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Patients using opioids or undergoing acute opioid withdrawal.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of two of the following: risperidone, aripiprazole, quetiapine IR and ER, ziprasidone, or asenapine (requires step therapy for new starts).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# MAVYRET

---

## Products Affected

- Mavyret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder), and 3) Documentation of presence or absence of cirrhosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MAYZENT

---

## Products Affected

- Mayzent
- Mayzent Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation that Mayzent is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MEBENDAZOLE

---

## Products Affected

- Emverm

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record confirmation of an infection caused by <i>Ancylostoma duodenale</i> (common hookworm), <i>Necator americanus</i> (American hookworm), <i>Enterobius vermicularis</i> (pinworm), <i>Trichuris</i> , (whipworm), or <i>Ascaris lumbricoides</i> (common roundworm).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MERCAPTOPURINE SUSPENSION

---

## Products Affected

- Mercaptopurine SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# METHOTREXATE SOLUTION

---

## Products Affected

- Jylamvo
- Xatmep

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid dosage forms. 2) For the treatment of cancer, Part B versus D determination will be made to determine coverage.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# METYROSINE

---

## Products Affected

- Metyrosine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of scheduled surgical resection or if no surgical intervention planned, documentation of contraindication to surgery or malignant pheochromocytoma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist, oncologist or nephrologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MIPLYFFA

---

## Products Affected

- Miplyffa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: a) confirmation of a diagnosis of Niemann-Pick disease type C (NPC) by genetic testing, b) documentation of neurologic symptoms due to NPC, and c) documentation that Miplyffa will be prescribed in combination with miglustat.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist or neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MODAFINIL

---

## Products Affected

- Modafinil TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: documentation of significant improvement in daytime sleepiness and functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Renewal: lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MOTTEGRITY

---

## Products Affected

- Prucalopride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of fewer than 3 spontaneous bowel movements per week.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MOUNJARO

---

## Products Affected

- Mounjaro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MOVANTIK

---

## Products Affected

- Movantik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Opioid-induced constipation in adults with chronic non-cancer pain: documentation of fewer than 3 spontaneous bowel movements per week.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MULPLETA

---

## Products Affected

- Mulpleta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Platelets less than 50k.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hematologist, hepatologist or surgeon.
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	Documentation of upcoming procedure.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MULTAQ

---

## Products Affected

- Multaq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	NYHA Class IV heart failure. Symptomatic heart failure with recent decompensation requiring hospitalization.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation of failure of or intolerance to amiodarone.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# MYALEPT

## Products Affected

- Myalept

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: 1) Laboratory test confirming leptin deficiency and 2) Documentation of complications of leptin deficiency such as hyperglycemia, diabetes, hypertriglyceridemia. Renewal criteria: Laboratory test results showing improvement in HbA1c, glucose and triglycerides from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with the FDA approved labeling.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# MYCAPSSA

---

## Products Affected

- Mycapssa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation showing: 1) a diagnosis of acromegaly, 2) response and tolerance to treatment with octreotide or lanreotide, and 3) that it is not appropriate to continue treatment with injection or depot. Renewal: documentation of IGF-1 normalization or symptom improvement.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# MYFEMBREE

---

## Products Affected

- Myfembree

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ob/gyn specialist.
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Failure of or contraindication to oral contraceptives.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# NAGLAZYME

## Products Affected

- Naglazyme

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) Diagnostic confirmation of mucopolysaccharidosis VI by lab results such as elevation of glycosaminoglycans (GAG) in the urine or deficiency in galactosamine-4-sulfatase enzyme activity, OR by genetic test confirmation, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression such as improvement in 12-minute walk test, rate of stair climbing, reduction in urinary GAG levels, or reduction in liver or spleen size.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: 1mg/kg IV once weekly.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# NERLYNX

---

## Products Affected

- Nerlynx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Drug must be prescribed for a FDA approved indication. If not prescribed for a FDA approved indication, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information, NCCN (National Comprehensive Cancer Network) guidelines, Micromedex DrugDex or peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# NITAZOXANIDE

## Products Affected

- Nitazoxanide TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Cryptosporidiosis in HIV infected patients
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For diagnosis of cryptosporidiosis in HIV infected patients: documentation that the patient is on antiretroviral therapy (ART) or if the patient is not on ART then ART is being initiated.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Cryptosporidiosis and Giardiasis: 3 days. Cryptosporidiosis, HIV: 14 days.
<b>Other Criteria</b>	For suspension: documentation that the tablet is not indicated for the member's age, or of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# NITYR

## Products Affected

- Nityr

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hereditary Tyrosinemia type 1 (HT-1) Initial: Medical record documentation of diagnostic confirmation of HT1 including laboratory testing (e.g. the presence of succinylacetone and tyrosyl compounds in urine or elevated plasma concentrations of tyrosine and methionine). Renewal: Improvement in urine succinylacetone (SA), liver function tests, alpha-fetoprotein, and serum tyrosine and phenylalanine levels. For the reduction of urine homogentisic acid (HGA) in adult patients with alkaptonuria (AKU), see criteria for Harliku.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# NUCALA

---

## **Products Affected**

- Nucala

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) For severe asthma with eosinophilic phenotype: Initial criteria: a) Medical record documentation of diagnosis and b) Blood eosinophil levels greater than 150 cells/mcL at baseline or greater than or equal to 300 cells/mcL. Renewal criteria: documentation of or claims history showing a reduction in the use of oral steroids or reduction in asthma symptoms. 2) For eosinophilic granulomatosis with polyangiitis (EGPA): Initial criteria: a) blood eosinophil level of 10% or an absolute count of greater than 1000 cells/mm <sup>3</sup> , and systemic vasculitis involving two or more extra-pulmonary organs. Renewal criteria: documentation of response to treatment such as achievement of remission, decrease in the use of steroids, decrease in the rate of relapses or improvement in asthma symptoms. 3) For hypereosinophilic syndrome (HES): Initial criteria: Medical record documentation showing that the diagnosis has a duration of at least 6 months, and does not have an identifiable nonhematologic secondary cause. Renewal: documentation of reduction in flares, or other clinical benefit from Nucala. 4) For the treatment of nasal polyps: Initial: a) documentation that Nucala is being used as add-on therapy, and b) documentation of an inadequate response to nasal corticosteroids. Renewal: Documentation of clinical benefit from Nucala. 5) For eosinophilic type chronic obstructive pulmonary disease (COPD): initial: a) eosinophil count of at least 300 cells/mcL. Renewal: documentation improvement in COPD, such as a reduction exacerbations or in the use of oral steroids or symptoms.
<b>Age Restrictions</b>	Asthma with eosinophilic phenotype: 6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for asthma, allergist, dermatologist, hematologist or immunologist for HES, allergist, immunologist, pulmonologist, rheumatologist, or vasculitis specialist for EGPA, ENT or otolaryngologist for nasal polyps.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For severe asthma with eosinophilic phenotype: Failure of an inhaled corticosteroid and a long-acting beta agonist.

<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.
--	--

# NUEDEXTA

## Products Affected

- Nuedexta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Complete atrioventricular block without implanted pacemaker or is at high risk for complete AV block.2) Concomitant use with drugs containing quinidine, quinine, mefloquine, drugs that prolong the QT interval and are metabolized by CYP2D6 (thioridazine and pimozide), monoamine oxidase inhibitors. 3) Heart failure. 4) Prolonged QT interval, congenital long QT syndrome or history suggesting torsades de pointes.
<b>Required Medical Information</b>	Renewal criteria: documentation of clinical benefit such as improvement in the Center for Neurologic Study Lability Scale or reduction in the number of laughing and crying episodes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# NULOJIX

## Products Affected

- Nulojix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation that Epstein-Barr virus status is positive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or transplant specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	To prevent or treat an organ transplant rejection, Part B versus D determination will be made to determine coverage. If the drug is to be covered by Part D and the patient is newly started on Nulojix, documentation of failure of tacrolimus and cyclosporine. Nulojix should be used in combination with basiliximab induction, mycophenolate mofetil and corticosteroids.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# NUPLAZID

---

## Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Medical record documentation of failure of or intolerance to clozapine or reason why clozapine cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# NURTEC

## Products Affected

- Nurtec

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Episodic migraine, initial: medical record documentation of 4-14 headache days per month. Episodic migraine, renewal: documentation of treatment response such as a decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Episodic migraine, initial: 6 months. Episodic renewal: 12 months. Acute migraine: lifetime
<b>Other Criteria</b>	1) Episodic migraine prophylaxis, initial and renewal: documentation that Nurtec is not being used with a second CGRP agent for migraine prophylaxis. 2) Acute migraine treatment: Failure of two triptans, such as eletriptan, sumatriptan, naratriptan, rizatriptan, or zolmitriptan, unless there is documentation of intolerance or a contraindication to triptans.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# Ocaliva

## Products Affected

- Ocaliva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Used in combination with ursodeoxycholic acid (UDCA) unless there is documentation of intolerance. Renewal: 1) Documentation of a reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist or GI specialist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: Failure to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 months of ursodeoxycholic acid (UDCA), or documented contraindication to UDCA.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OCREVUS

---

## Products Affected

- Ocrevus
- Ocrevus Zunovo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation that Ocrevus is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OMNIPOD

---

## **Products Affected**

- Omnipod 5 Dexcom G7g6 Intro Kit (gen 5)
- Omnipod 5 Dexcom G7g6 Pods (gen 5)
- Omnipod 5 G7 Intro Kit (gen 5)
- Omnipod 5 G7 Pods (gen 5)
- Omnipod 5 Libre2 Plus G6 Intro Gen 5
- Omnipod 5 Libre2 Plus G6 Pods
- Omnipod Classic Pods (gen 3)
- Omnipod Dash Intro Kit (gen 4)
- Omnipod Dash Pdm Kit (gen 4)
- Omnipod Dash Pods (gen 4)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For all: a diagnosis of diabetes. The following criteria apply to those age 21 and older: 1) the member completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen: a) Glycosylated hemoglobin level (HbA1c) greater than 7.0%, b) History of recurring hypoglycemia, c) Wide fluctuations in blood glucose before mealtime, d) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl, or e) History of severe glycemic excursions. OR 2) the member has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OPFOLDA

---

## Products Affected

- Opfolda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) medical record documentation of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) not improving on current enzyme replacement therapy, 2) weight of at least 40kg, and 3) documentation that Opfolda will be used in combination with cipagluosidase alfa-atga.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OPIPZA

---

## Products Affected

- Opiqua

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OPIUM TINCTURE

---

## Products Affected

- Opium
- Opium Tincture TINC 1%

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of or contraindication to diphenoxylate/atropine and loperamide.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OPSUMIT

---

## Products Affected

- Opsumit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Documentation of World Health Organization (WHO) functional class II-IV or New York Heart Association (NYHA) Class II-IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or contraindication to 1) sildenafil or tadalafil and 2) bosentan or ambrisentan. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORAL IMMUNOTHERAPY

---

## Products Affected

- Grastek
- Odactra
- Ragwitek

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For Grastek: documentation of a positive skin test or pollen specific IgE antibodies to Timothy grass or cross-reactive grass pollens. For Odactra, documentation of a positive skin test to licensed house dust mite allergen extracts or positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites.
<b>Age Restrictions</b>	65 years of age or younger
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist or immunologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or contraindication to 1) an oral or nasal antihistamine such as desloratadine tablets or azelastine nasal spray) and 2) an intranasal corticosteroid such as flunisolide nasal spray.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORAL RIBAVIRIN

---

## Products Affected

- Ribavirin CAPS
- Ribavirin TABS 200MG

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder), and 3) Documentation of presence or absence of cirrhosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Other Criteria</b>	Ribavirin will be approved consistent with FDA approved labeling or AASLD/IDSA guidelines as part of treatment regimens consisting of ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, and Pegasys if criteria for these drugs are met. For non-formulary drugs such as Sovaldi or Daklinza approved based on the prescriber's supporting statement that all formulary drugs would not be as effective or safe as the non-formulary drug, ribavirin will be approved as requested consistent with FDA approved labeling or AASLD/IDSA guidelines.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ORAL TRANSMUCOSAL FENTANYL

## Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Not approved for use of acute or postoperative pain and for opioid non-tolerant patients.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, palliative care prescriber, or pain specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Documentation of 1) Failure of two short-acting opioids (eg, oxycodone, morphine sulfate, etc) or an inability to swallow, dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting AND 2) Patient is on or will be on a long-acting narcotic (eg, methadone, morphine sulfate ER, oxycodone ER, fentanyl), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORENCIA

## Products Affected

- Orencia
- Orencia Clickject

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Juvenile idiopathic arthritis (JIA) renewal: Improved functioning and/or improvement in tender joint count and swollen joint count. 2) Psoriatic Arthritis (PsA) Renewal: Improved functioning and/or decreased in the number of tender, swollen joints and reduction in skin lesions and/or has disease stability. 3) Prophylaxis of acute graft versus host disease (aGVHD): a) documentation that Orencia will be used with a calcineurin inhibitor and methotrexate, and b) documentation that the patient will be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor. 4) Rheumatoid arthritis (RA) renewal: Improved functioning and/or improvement in tender joint count and swollen joint count.
<b>Age Restrictions</b>	JIA: 6 years of age or older for Orencia IV and 2 years of age or older for Orencia subcutaneous injection
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, hematologist, oncologist or transplant specialist for aGVHD, rheumatologist for JIA, RA.
<b>Coverage Duration</b>	aGVHD: 28 days. All other indications: Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	JIA initial: failure of an 8-week trial of methotrexate. RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORENITRAM

---

## Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Documentation of WHO Group 1 pulmonary arterial hypertension diagnosed by right heart catheterization. 2) Documentation of New York Heart Association (NYHA) Class III to IV. Renewal: Documentation of clinical improvement or disease stability such as increased exercise capacity, improvement in WHO functional class or decreased clinical worsening events.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist.
<b>Coverage Duration</b>	Initial: 12 months. Renewal: Lifetime.
<b>Other Criteria</b>	Failure of or contraindication to 1) sildenafil or tadalafil and 2) bosentan or ambrisentan. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORFADIN

## Products Affected

- Nitisinone
- Orfadin SUSP

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of diagnostic confirmation of HT1 including laboratory testing (e.g. the presence of succinylacetone and tyrosyl compounds in urine or elevated plasma concentrations of tyrosine and methionine). Renewal: Improvement in urine succinylacetone (SA), liver function tests, alpha-fetoprotein, and serum tyrosine and phenylalanine levels.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: initial 1 mg/kg/day (divided into 2 doses) titrated to achieve suppression of SA, maximum 2 mg/kg/day. For Orfadin Suspension: Documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ORGOVYX

---

## Products Affected

- Orgovyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of an FDA approved or medically accepted indication.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with oncologist or urologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# Oriahnn

---

## Products Affected

- Oriahnn

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ob/gyn specialist.
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Failure of or contraindication to: 1) oral contraceptives and 2) tranexamic acid.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ORILISSA

---

## Products Affected

- Orilissa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ob/gyn specialist.
<b>Coverage Duration</b>	EM: 24 months. EM with dyspareunia: 6 months. EM with moderate hepatic impairment: 6 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ORKAMBI

## Products Affected

- Orkambi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of a diagnosis of cystic fibrosis homozygous for the F508del mutation confirmed using an FDA-cleared cystic fibrosis mutation test. Renewal criteria: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For Orkambi Pack (Suspension): documentation of an inability to swallow solid dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OSENVELT

## Products Affected

- Osenvelt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Preexisting hypocalcemia and pregnancy.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) For bone metastasis associated with solid tumors and prevention of skeletal related events in patients with multiple myeloma: documentation of failure of zoledronic acid or there is a contraindication to zoledronic acid that is not a contraindication to denosumab. 2) For the treatment of hypercalcemia of malignancy: failure of one IV bisphosphonate including zoledronic acid or pamidronate.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OTEZLA

## Products Affected

- Otezla
- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Bechet's syndrome (BS) initial: medical record documentation of oral ulcer's caused by Bechet's syndrome. BS renewal: medical record documentation of reduction in severity of oral ulcers or improvement in symptoms. 3) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: documentation of baseline BSA involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA or BS.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months
<b>Other Criteria</b>	Mild PsO initial: failure of 1) one topical corticosteroid (i.e. betamethasone or clobetasol), and 2) one of the following: calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization). Moderate to severe PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OVERACTIVE BLADDER DRUGS

---

**Products Affected**

- Oxybutynin Chloride SOLN
- Oxybutynin Chloride TABS 5MG
- Oxybutynin Chloride Er
- Solifenacin Succinate
- Tolterodine Tartrate
- Tolterodine Tartrate Er
- Trospium Chloride
- Trospium Chloride Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	The following criteria applies to members age 60 and older: medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OXERVATE

---

## Products Affected

- Oxervate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of neurotrophic keratitis.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist.
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# OXYCODONE EXTENDED RELEASE

---

**Products Affected**

- Oxycodone Hydrochloride Er T12A  
10MG, 20MG, 40MG
- Oxycontin T12A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of sustained release morphine sulfate and not receiving concurrent therapy with another long-acting opioid, such as fentanyl or sustained release morphine sulfate.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# OZEMPIC

---

## Products Affected

- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PALIPERIDONE EXTENDED RELEASE INJECTION

---

**Products Affected**

- Invega Hafyera
- Invega Trinza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug. 1) For Invega Hafyera: medical record documentation or evidence from claims history that Invega Sustenna has been used for 4 months OR that Invega Trinza has been used for 3 months. 2) For Invega Trinza: medical record documentation or evidence from claims history that Invega Sustenna has been used for 4 months.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PALYNZIQ

---

## Products Affected

- Palynziq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Phenylalanine level (Phe) at or above 600 micromol/L. Renewal: Reduction in Phe levels.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PANRETIN

---

## Products Affected

- Panretin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of cutaneous lesions associated with AIDS-related Kaposi's sarcoma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

## PARENTERAL BISPHOSPHONATES

### Products Affected

- Pamidronate Disodium INJ 30MG/10ML, 6MG/ML, 90MG/10ML
- Zoledronic Acid INJ 4MG/100ML, 4MG/5ML, 5MG/100ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy: albumin-corrected serum calcium above 12mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) For the diagnosis of osteoporosis: failure of two oral bisphosphonates such as ibandronate and alendronate or reason why bisphosphonates cannot be used. Risedronate is available after failure of ibandronate and alendronate. 2) For end stage renal disease (ESRD) patients on dialysis, Part B versus Part D determination will be made to determine if the drug prescribed will be used for an ESRD-related condition. For ESRD-related conditions, the drug will be covered under Part B and provided by the dialysis center.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

# PARICALCITOL

## Products Affected

- Paricalcitol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Hypercalcemia and vitamin D toxicity.
<b>Required Medical Information</b>	1) Stage 3 Chronic Kidney Disease (CKD): a) GFR 30-59, b) serum calcium less than 9.5 mg/dL, c) serum phosphorus less than or equal to 4.6 mg/dL. 2) Stage 4 CKD: a) GFR 15-29, b) serum calcium less than 9.5 mg/dL, c) serum phosphorus less than or equal to 4.6 mg/dL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	1) Failure of or intolerance to calcitriol or reason why calcitriol cannot be used. 2) For end stage renal disease (ESRD) patients, Part B versus Part D determination will be made to determine if the drug prescribed will be used for an ESRD-related condition. For ESRD-related conditions, the drug will be covered under Part B and provided by the dialysis center.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PAROXETINE SUSPENSION

---

## Products Affected

- Paroxetine Hydrochloride SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Documentation of 1) An inability to take solid oral dosage forms and 2) Failure of or contraindication to sertraline solution.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PEGASYS

## Products Affected

- Pegasys

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) For the treatment of hepatitis B (HBV): a) Compensated cirrhosis and HBV DNA greater than 2000 IU/ml or b) If HBeAg positive, HBV DNA at least 20,000 IU/ml and serum ALT is persistently elevated after 3-6 months or liver biopsy shows at least moderate inflammation or significant fibrosis or c) If HBeAg negative, HBV DNA greater than 2000 IU/ml and serum ALT is persistently elevated after 3-6 months or liver biopsy shows at least moderate inflammation or fibrosis. 2) For the treatment of hepatitis C (HCV): Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder), and 3) Documentation of presence or absence of cirrhosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, Hepatitis C specialist or hepatologist.
<b>Coverage Duration</b>	HBV 12 mo. HCV: 48 weeks
<b>Other Criteria</b>	For the treatment of Hepatitis C, pegylated interferon is no longer standard of care. Refer to criteria for Mavyret, sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, and Vosevi.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PENBRAYA

---

## Products Affected

- Penbraya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Between 10 years and 25 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PENMENVY

---

## Products Affected

- Penmenvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prior authorization does not apply to members between 10 years and 25 years of age.
<b>Age Restrictions</b>	Between 10 years and 25 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PENTAMIDINE

---

## Products Affected

- Pentamidine Isethionate INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, oncologist, or hematologist.
<b>Coverage Duration</b>	21 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PENTOSAN POLYSULFATE SODIUM

---

## Products Affected

- Elmiron

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Hemorrhagic cystitis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: medical record documentation of an improvement in symptoms such as a reduction in bladder pain.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PERAMPANEL

## Products Affected

- Perampanel TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For the treatment of partial-onset seizures: failure of two of the following: carbamazepine, oxcarbazepine, lacosamide, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, and levetiracetam. 2) For the treatment of primary generalized tonic-clonic seizures: failure of two of the following topiramate, lacosamide, lamotrigine, phenytoin, and levetiracetam.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PERAMPANEL SUSPENSION

---

## Products Affected

- Perampanel SUSP

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For the treatment of partial-onset seizures: failure of two of the following: carbamazepine, oxcarbazepine, lacosamide, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, and levetiracetam. 2) For the treatment of primary generalized tonic-clonic seizures: failure of two of the following topiramate, lacosamide, lamotrigine, phenytoin, and levetiracetam. For all indications: inability to swallow oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PIMECROLIMUS

---

## Products Affected

- Pimecrolimus

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Primary cutaneous lymphomas
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For treatment of primary cutaneous lymphomas: documentation of mycosis fungoides.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist or oncologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For treatment of atopic dermatitis, initial: failure of 1) tacrolimus ointment and 2) if older than 12 years of age: a high potency steroid such as clobetasol.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PLERIXAFOR

---

## Products Affected

- Plerixafor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	4 days
<b>Other Criteria</b>	Use in combination with a granulocyte colony stimulating factor.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# POSACONAZOLE

---

## Products Affected

- Noxafil PACK
- Posaconazole
- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Candidiasis: 1 month. Aspergillosis: 3 months. Prophylaxis of invasive fungal infections: 6 months.
Other Criteria	For oropharyngeal candidiasis or prophylaxis of invasive fungal infections in a patient who has received a hematopoietic stem-cell transplant or has chemotherapy-induced neutropenia due to hematologic malignancy: failure of fluconazole or itraconazole. For suspension only: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

## POTASSIUM BINDERS

---

### Products Affected

- Lokelma
- Veltassa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: medical lab documentation of hyperkalemia. Renewal criteria: reduction in serum potassium from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PRALUENT

---

## Products Affected

- Praluent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial Criteria: 1) For reducing the risk of major adverse cardiovascular (CV) events for patients with established atherosclerotic cardiovascular disease (ASCVD), or for patients that are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. 2) For treatment of hypercholesterolemia or primary heterozygous familial hypercholesterolemia (HeFH): a) in patients with established ASCVD, or who are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. b) in patients without ASCVD and who are at a low risk for major adverse CV events: LDL-C of 70mg/dL or greater. 3) Homozygous familial hypercholesterolemia (HoFH): diagnosis confirmed by genetic testing, or by documentation of either a) untreated LDL-C greater than 500 mg/dL, or b) treated LDL-C greater than 300 mg/dL, AND i) xanthoma before 20 years of age or ii) evidence of heterozygous familial hypercholesterolemia in both parents. Renewal criteria for all indications: documentation of LDL reduction from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	For all indications: Medical record documentation of failure of, documented contraindications, or intolerance or significant side effects on one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# PRENATAL VITAMINS

---

## Products Affected

- Pnv Prenatal Plus Multivitamin + Dha
- Prenatal TABS 120MG; 0; 200MG; 10MCG; 2MG; 12MCG; 27MG; 1MG; 20MG; 10MG; 1200MCG; 3MG; 1.84MG; 10MG; 25MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Male gender
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Prior authorization is only required for patients 51 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PRETOMANID

## Products Affected

- Pretomanid

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Drug-sensitive tuberculosis, latent infection due to Mycobacterium tuberculosis, extra-pulmonary infection due to Mycobacterium tuberculosis, or MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy.
<b>Required Medical Information</b>	Medical record documentation of 1) Extensively drug resistant pulmonary tuberculosis confirmed by culture and drug sensitivity, 2) Pretomanid will be used in combination with Sirturo and linezolid.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease or tuberculosis (TB) specialist.
<b>Coverage Duration</b>	26 weeks
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# PREVYMIS

## Products Affected

- Prevymis INJ
- Prevymis TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of 1) the patient is receiving or will receive an allogenic hematopoietic stem cell transplant and is at risk for cytomegalovirus (CMV) infection because of the patient's CMV-seropositive status or the donor's status. OR 2) that the patient is receiving or will receive a kidney transplant and is at high risk of CMV infection.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	200 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

## PULMONARY FIBROSIS AGENTS

---

### Products Affected

- Nintedanib Esylate
- Ofev
- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A) Idiopathic pulmonary fibrosis, initial criteria: medical record documentation of the diagnosis of idiopathic pulmonary fibrosis based on the presence of a usual interstitial pneumonia pattern on high-resolution computed tomography or surgical lung biopsy. B) Systemic sclerosis-associated interstitial lung disease, initial, (Ofev only): medical record documentation of systemic sclerosis-associated interstitial lung disease. Renewal criteria (all diagnoses): medical record documentation of a decrease in the decline in force vital capacity (FVC).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

# PYRUKYND

## Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of a diagnosis of hemolytic anemia with pyruvate kinase deficiency confirmed by genetic testing. Renewal: documentation of a reduction in transfusion requirements from baseline.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, oncologist, or genetic specialist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# QBREXZA

---

## Products Affected

- Qbrexza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: medical record documentation of an improvement in symptoms.
<b>Age Restrictions</b>	9 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# QUININE SULFATE

---

## Products Affected

- Quinine Sulfate CAPS 324MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RALDESY

---

## Products Affected

- Raldesy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concomitant use of monoamine oxidase inhibitors (MAOIs), or use within 14 days of stopping MAOIs.
<b>Required Medical Information</b>	1) Medical record documentation of a diagnosis of major depressive disorder.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documented inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# REDEMPLO

## Products Affected

- Redemplo

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Familial Chylomicronemia Syndrome (FCS), initial: confirmation of a diagnosis of Familial Chylomicronemia Syndrome (FCS) with a) lab test results showing fasting TG levels $\geq 880$ mg/dL and b) either a history of pancreatitis OR a genetic test confirming FCS. FCS, Renewal: 1) Lab results showing a reduction in triglycerides from baseline, and 2) documentation of clinical improvement such as episodes of acute pancreatitis.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, lipid specialist, or pancreatologist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RELISTOR

## Products Affected

- Relistor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Known or suspected mechanical gastrointestinal obstruction.
<b>Required Medical Information</b>	1) For the treatment of opioid-induced constipation in patients with advanced illness receiving palliative care: a) Receiving palliative care for advanced illness and b) Receiving chronic opioid therapy. 2) For the treatment of opioid-induced constipation in patients with chronic noncancer pain: a) documentation of less than 3 spontaneous bowel movements per week b) Receiving chronic opioid therapy for at least one month.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For the treatment of opioid-induced constipation in patients receiving palliative care and using injections, dosing consistent with product label: a) 38 kg to less than 62 kg, 8 mg/dose. b) 62 kg to 114 kg, 12 mg/dose. c) Less than 38 kg or greater than 114 kg, 0.15/kg/dose.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# REPATHA

---

## **Products Affected**

- Repatha
- Repatha Sureclick

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial Criteria: 1) For reducing the risk of major adverse cardiovascular (CV) events for patients with established atherosclerotic cardiovascular disease (ASCVD), or for patients that are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. 2) For treatment of hypercholesterolemia or primary heterozygous familial hypercholesterolemia (HeFH): a) in patients with established ASCVD, or who are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. b) in patients without ASCVD and who are at a low risk for major adverse CV events: LDL-C of 70mg/dL or greater. 3) Homozygous familial hypercholesterolemia (HoFH): diagnosis confirmed by genetic testing, or by documentation of either a) untreated LDL-C greater than 500 mg/dL, or b) treated LDL-C greater than 300 mg/dL, AND i) xanthoma before 20 years of age or ii) evidence of heterozygous familial hypercholesterolemia in both parents. Renewal criteria for all indications: documentation of LDL reduction from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	For all indications: Medical record documentation of failure of, documented contraindications, or intolerance or significant side effects on one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# REVCOVI

---

## Products Affected

- Revcovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: laboratory result confirmation of a diagnosis of adenosine deaminase severe combined immune deficiency (ADASCID). Renewal: medical record documentation of a clinical response to Revcovi, and that monitoring recommended per the FDA labeling is being completed.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an immunologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# REYVOW

---

## Products Affected

- Reyvow

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of two triptans, such as eletriptan, sumatriptan, naratriptan, rizatriptan, or zolmitriptan, unless there is documentation of intolerance or a contraindication to triptans.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# REZDIFFRA

---

## Products Affected

- Rezdiffra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: a) Medical record documentation of noncirrhotic nonalcoholic steatohepatitis (NASH). 2) Documentation of moderate to advanced liver fibrosis, Stage F2 or F3.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist or gastroenterologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# REZUROCK

---

## Products Affected

- Rezero

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of a diagnosis of chronic graft vs host disease.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, hematologist, or transplant specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For patients age 18 and older: Failure of or contraindication to 1) Jakafi and 2) Imbruvica. Both require prior authorization. For patients age 12 to 17: Failure of or contraindication to Jakafi.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# RINVOQ

---

## **Products Affected**

- Rinvoq
- Rinvoq Lq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>1) Ankylosing spondylitis (AS) initial: inadequate response or intolerance to a TNF inhibitor. AS Renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis initial (nr-axSpA): inadequate response or intolerance to a TNF inhibitor. nr-axSpA renewal: improved functioning and/or improvement in signs and symptoms of nr-axSpA. 3) Atopic dermatitis (AD) initial: body surface area involvement of at least 10% at baseline. AD renewal: medical record documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, or improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline. 4) Crohn's disease (CD) and ulcerative colitis (UC): initial: a) moderate to severe disease activity, and b) inadequate response or intolerance a TNF inhibitor OR if treatment is inadvisable (ie, CI) with a TNF-I, pt has had a trial of a systemic therapy approved for CD/UC (eg, risankizumab, ustekinumab). CD and UC renewal: medical record documentation of treatment response such as decrease in symptoms or clinical remission. 5) Polyarticular juvenile idiopathic arthritis (pJIA): initial: inadequate response or intolerance to a TNF inhibitor such as adalimumab. pJIA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Psoriatic arthritis (PsA) initial: inadequate response or intolerance to a TNF inhibitor. PsA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 7) Rheumatoid arthritis (RA) initial: inadequate response or intolerance to a TNF inhibitor. RA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 8) Giant cell arteritis (GCA), renewal: clinical remission or a reduction in signs and symptoms from baseline.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: allergist, dermatologist or immunologist for AD, dermatologist or rheumatologist for PsA, gastroenterologist for UC and CD, rheumatologist for AS, nr-axSpA, pJIA, RA.

<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AD initial: Failure of or contraindication to a) one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and b) tacrolimus ointment. AS and nr-axSpA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. pJIA initial: failure of an 8 week trial of methotrexate. RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# RIOCIGUAT

## Products Affected

- Adempas

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: 1) For patients with WHO Group 4 pulmonary arterial hypertension - chronic thromboembolic pulmonary arterial hypertension: failure of surgical treatment or would not be a candidate for surgical treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Initial criteria for patients with WHO Group 1 pulmonary arterial hypertension: Medical record documentation of failure of or would be a poor candidate for the following: 1) A phosphodiesterase type 5 (PDE-5) inhibitor such as sildenafil or tadalafil and 2) An endothelin receptor antagonist such as ambrisentan or bosentan.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# RISEDRONATE

---

## Products Affected

- Risedronate Sodium

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Osteoporosis: failure of alendronate and ibandronate. Paget's disease: failure of alendronate.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# RITUXIMAB

---

## Products Affected

- Riabni
- Rituxan
- Ruxience
- Truxima

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) renewal: medical record documentation of a 20% or greater improvement in tender joint count and swollen joint count or a reduction in specific, objective pain symptoms and/or improved functioning.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, rheumatologist or dermatologist.
<b>Coverage Duration</b>	NHL, CLL, WG, MPA and pemphigus vulgaris: Lifetime. RA Initial: 6 months. RA Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RIVAROXABAN SUSPENSION

---

## Products Affected

- Rivaroxaban SUSR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation of an inability to swallow oral tablets.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RIVFLOZA

---

## Products Affected

- Rivfloza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Confirmation of primary hyperoxaluria type 1 (PH1) with elevated urinary oxalate excretion and genetic testing. Renewal: medical record documentation of reduction in urinary oxalate excretion.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ROZLYTREK PELLETT

---

## Products Affected

- Rozlytrek PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of the diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to new starts only. Initial: Documentation of an inability to swallow solid oral dosage forms. Drug must be prescribed for a FDA approved indication or a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex for non-cancer indications, and supported by NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, and acceptable medical journals for cancer indications.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RSV VACCINE

---

## Products Affected

- Arexvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prior authorization does not apply to members age 50 years of age or older.
<b>Age Restrictions</b>	50 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RUFINAMIDE SUSPENSION

---

## Products Affected

- Rufinamide SUSP 40MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documentation of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RYBELSUS

---

## Products Affected

- Rybelsus TABS 14MG, 3MG, 7MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# RYTARY

---

## Products Affected

- Rytary

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or movement disorder specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of carbidopa/levodopa ER tablets.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SANDOSTATIN LAR

---

## Products Affected

- Octreotide Acetate INJ 10MG, 20MG, 30MG
- Sandostatin Lar Depot

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) For the treatment of acromegaly: a) Initial: medical record documentation of failure of surgery, radiation or bromocriptine or reason or reason why surgery, radiation or bromocriptine are not options. b) Renewal: documentation of IGF-1 normalization or symptom improvement. 2) Renewal criteria for all other conditions: reduction in symptoms such as stool frequency.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the treatment of acromegaly, metastatic carcinoid tumors and vasoactive intestinal peptide tumors: documentation of response to and tolerance to octreotide immediate release injection.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SAPHNELO

## Products Affected

- Saphnelo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Severe active CNS lupus or used in combination with IV cyclophosphamide
<b>Required Medical Information</b>	Initial criteria: 1) Medical record documentation of a diagnosis of systemic lupus erythematosus (SLE) and is auto-antibody positive as defined as Antinuclear antibody (ANA titer) greater than or equal to 1:80 or anti-double stranded DNA antibody (Anti-dsDNA) greater than or equal to 30 IU/ml. 2) Receiving standard therapy including NSAIDs, antimalarials, corticosteroids or immunosuppressants. Renewal criteria: medical record documentation of treatment response such as an improvement in the SELENA-SLEDAI score or no worsening of disease activity.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SAPROPTERIN

---

## Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: Documentation of response to therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SAVELLA

---

## Products Affected

- Savella
- Savella Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of fibromyalgia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of two of the following: pregabalin, duloxetine, or amitriptyline.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SCOPOLAMINE PATCH

---

## Products Affected

- Scopolamine PT72 1MG/3DAYS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Excessive salivation prophylaxis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Post-op nausea and vomiting and motion sickness: 1 month. Excessive salivation: 12 months.
<b>Other Criteria</b>	For the treatment of motion sickness: failure of or intolerance to meclizine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SECUADO

---

## Products Affected

- Secuado

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation of trial of, intolerance to, or contraindication to asenapine sublingual tablets (requires step therapy for new starts).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SEPHIENCE

---

## Products Affected

- Sephience

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation supporting a diagnosis of hyperphenylalaninemia with sepiapterin-responsive phenylketonuria (PKU). Renewal: Documentation of a clinical response to therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or metabolic specialist.
<b>Coverage Duration</b>	Initial: 3 months. Renewal: Lifetime
<b>Other Criteria</b>	Initial: failure of sapropterin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SIGNIFOR

---

## Products Affected

- Signifor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal criteria: decrease in urinary free cortisol or improvement in signs or symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SIKLOS

---

## Products Affected

- Siklos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of sickle cell anemia with crisis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

## SILDENAFIL (PULMONARY ARTERIAL HYPERTENSION)

---

### Products Affected

- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concurrent therapy with nitrates.
<b>Required Medical Information</b>	Documentation of New York Heart Association (NYHA) Functional Class II-IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For oral suspension: documentation of a reason why sildenafil tablets cannot be used such as failure, inability to swallow oral dosage form, or contraindication that is also not a contraindication to the suspension.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SIMPONI

## Products Affected

- Simponi
- Simponi Aria

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS.2) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, gastroenterologist for UC, rheumatologist for AS and RA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS initial: failure of one oral nonsteroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SIRTURO

---

## Products Affected

- Sirturo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of 1) multi-drug resistant pulmonary tuberculosis confirmed by culture and drug sensitivity and must be resistant to at least isoniazid and rifampin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease or tuberculosis (TB) specialist.
<b>Coverage Duration</b>	24 weeks
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SKYCLARYS

---

## Products Affected

- Skyclarys

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of Friedreich's ataxia (FA or FRDA) confirmed by genetic testing. Renewal: medical record documentation of a slowing of progression or clinical benefit.
<b>Age Restrictions</b>	16 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SKYRIZI

---

## **Products Affected**

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML
- Skyrizi Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal criteria: decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning. 4) Ulcerative colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	PsO initial: failure of a) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization), and b) methotrexate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SODIUM PHENYL BUTYRATE

## Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Use as emergency treatment of acute hyperammonemia.
<b>Required Medical Information</b>	Initial: Medical record documentation of diagnostic confirmation by plasma quantitative amnio acid analysis or urinary orotic acid testing or enzyme activity from a liver biopsy or genetic testing. Renewal: Medical record documentation of stabilization of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Dosing consistent with product label: Usual total daily dose is 450-600mg/kg/day in patients weighing less than 20kg, or 9.9-13.0 G/m2/day in larger patients. Maximum dose is 20 G/day.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

## SOFOSBUVIR/VELPATASVIR

---

### Products Affected

- Epclusa PACK
- Epclusa TABS 200MG; 50MG
- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder), and 3) Documentation of presence or absence of cirrhosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SOHONOS

---

## Products Affected

- Sohonos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of a diagnosis of fibrodysplasia ossificans progressiva (FOP), confirmed by ACVR1 R206H mutation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SOLTAMOX

---

## Products Affected

- Soltamox

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concomitant coumarin-type anticoagulant therapy or in women with a history of deep vein thrombosis or pulmonary embolus.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Documentation of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SOMATROPINS

---

## **Products Affected**

- Genotropin
- Genotropin Miniquick
- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Omnitrope
- Zorbtive

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Short bowel syndrome
<b>Exclusion Criteria</b>	1) In patients with Prader-Willi syndrome, patients who are severely obese, have a history of upper airway obstruction, sleep apnea or severe respiratory impairment. 2) Not approved for the treatment of acute critical illness, respiratory failure or patients with an underlying intracranial tumor.
<b>Required Medical Information</b>	1) Growth Hormone Deficiency (GHD): a) short stature (SS) defined by one of the following:(i) height more than 3 standard deviations (SD) below mean for age and gender or (ii) height below the 3rd percentile for age and gender or (iii) height more than 2 SD below mean and growth velocity (GV) below the 25th percentile for age and gender or (iv) growth velocity less than 2 SD below the mean for age and gender AND b) laboratory results consistent with growth hormone deficiency. 2) Idiopathic SS: short stature as defined under GHD. 3) Prader-Willi syndrome: confirmed by genetic testing or decreased muscle tone by exam. 4) Turner's Syndrome and short-stature homeobox-containing gene (SHOX) deficiency: confirmation of diagnosis by genetic testing. 5) Small for gestational age (SGA) with no catch-up growth by age 2 to 4 years: height remains less than 2 SD below the mean for age and gender. 6) Adult-Onset GHD: a) Pituitary, hypothalamic disease, or GHD as a result of tumor, irradiation, surgery or trauma AND b) laboratory results consistent with growth hormone deficiency. 7) Childhood-Onset Adult GHD: a) laboratory results consistent with growth hormone deficiency. Renewal for all: documentation of improved quality of life or clinical benefit.
<b>Age Restrictions</b>	Short bowel syndrome (SBS): 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist, gastroenterologist, or nephrologist.
<b>Coverage Duration</b>	SBS: 4 weeks. All other diagnoses: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SOMATULINE DEPOT

---

## Products Affected

- Lanreotide Acetate
- Somatuline Depot INJ 60MG/0.2ML, 90MG/0.3ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) For the treatment of acromegaly and Carcinoid Syndrome: failure of octreotide or reason why octreotide cannot be used. 2) The following criteria applies to members who newly start on the drug for gastroenteropancreatic neuroendocrine tumors: failure of octreotide or reason why octreotide cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

# SOMAVERT

---

## Products Affected

- Somavert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Baseline liver function tests are not greater than 3 times the upper limit of normal.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SOTYLIZE

---

## Products Affected

- Sotylize

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Medical record documentation of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SPRAVATO

## Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug: 1) For treatment resistant major depressive disorder: medical record documentation of failure of separate 6 week trials of two different antidepressants . 2) For treatment of depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior: documentation that Spravato will be used in conjunction with an oral antidepressant.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a psychiatrist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SPRITAM

---

## **Products Affected**

- Levetiracetam TB3D
- Spritam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Evidence from documentation or claims history that Spritam is not being used as monotherapy for myoclonic seizures or primary generalized tonic-clonic seizures.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For the treatment of partial-onset seizures, failure of the following: a) levetiracetam tablets or oral solution and b) one of the following: carbamazepine tablet/chew tablet/suspension, oxcarbazepine tablet/suspension, phenytoin capsule/chew tablet/suspension, topiramate, divalproex, felbamate tablet/suspension, tiagabine, lamotrigine tablet/chew tablet/oral disintegrating tablet, gabapentin tablet/capsule/solution, lacosamide tablet/suspension or zonisamide. 2) For the treatment of primary generalized tonic-clonic seizures, failure of the following: a) levetiracetam tablets or oral solution and b) one of the following: topiramate, lamotrigine tablet/chew tablet/oral disintegrating tablet, phenytoin capsule/chew tablet/suspension, lacosamide tablet/suspension or carbamazepine tablet/chew tablet/suspension. 3) For the treatment of myoclonic seizures. failure of the following: a) levetiracetam tablets or oral solution and b) one of the following: divalproex, lamotrigine tablet/chew tablet/oral disintegrating tablet or topiramate.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# STAMARIL

---

## Products Affected

- Stamaril

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of planned travel to a country at risk for yellow fever. Renewal: Documentation that it has been at least 10 years since the previous dose, or that a booster is recommended to travel to a specific country.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# STRENSIQ

---

## Products Affected

- Strensiq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis confirmed by genetic testing, low serum activity of alkaline phosphatase or elevated pyridoxine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist, geneticist or metabolic specialist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SUCRAID

## Products Affected

- Sucraid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Diagnosis confirmed by one of the following: a) acidic stool pH less than 6, b) increase in breath hydrogen of greater than 10 ppm when challenged with sucrose or c) genetic testing showing sucrase deficiency and 2) Objective, measurable treatment goals are provided. Renewal: medical record documentation of treatment response such as improvement in growth and development or decrease in diarrhea, flatulence or abdominal pain.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist, gastroenterologist or metabolic specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: Weight greater than 15kg: 17,000 IU per meal or snack. Weight less than 15kg: 8,500 IU per meal or snack.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SYMDEKO

---

## Products Affected

- Symdeko

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of a diagnosis of cystic fibrosis homozygous for the F508del mutation or has a mutation that is responsive to the drug confirmed using an FDA-cleared cystic fibrosis mutation test. Renewal criteria: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SYMPAZAN

## Products Affected

- Sympazan

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Sympazan must be used as adjunctive treatment.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: 1) For Lennox-Gastaut, petit mal variant, failure of a) clonazepam and b) one of the following: valproate, topiramate, lamotrigine, felbamate or rufinamide. 2) For Lennox-Gastaut, other seizure types, failure of two of the following: clonazepam, valproate, topiramate, lamotrigine, felbamate or rufinamide. 3) For all indications, documentation of an inability to swallow solid and liquid dosage forms (tablets and suspension).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# SYMPROIC

---

## Products Affected

- Symproic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of fewer than 3 spontaneous bowel movements per week.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SYNAREL

## Products Affected

- Synarel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
<b>Age Restrictions</b>	Central precocious puberty: for females, 11 years of age or younger. For males age 12 years of age or younger. Endometriosis: 18 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: endocrinologist for CPP, ob/gyn for EM.
<b>Coverage Duration</b>	Endometriosis: 6 months. Central precocious puberty: until age 11 for females and age 12 for males.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# SYSTEMIC TESTOSTERONE

## Products Affected

- Methitest

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Men with carcinoma of the breast. 2) Men with known or suspected carcinoma of the prostate.
<b>Required Medical Information</b>	1) For members newly started on the drug for the treatment of primary or secondary hypogonadism: a) total testosterone level less than 300 ng/dL or b) free testosterone level below the normal range for age and gender. 2) Delayed puberty: Skeletal age of at least 12 or chronological age of at least 14.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist for metastatic breast cancer.
<b>Coverage Duration</b>	Delayed puberty: 6 months. All other diagnoses: Lifetime.
<b>Other Criteria</b>	For treatment of secondary hypogonadism: failure of testosterone cypionate and topical testosterone gel.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

## TADALAFIL (BENIGN PROSTATIC HYPERPLASIA)

---

### Products Affected

- Tadalafil TABS 2.5MG, 5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of a diagnosis of benign prostatic hyperplasia (BPH). Renewal: medical record documentation of an improvement in symptoms of BPH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Initial: failure of 1) an alpha blocker such as tamsulosin or alfuzosin and 2) an alpha reductase inhibitor such as finasteride or dutasteride.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TADALAFIL (PULMONARY ARTERIAL HYPERTENSION)

---

**Products Affected**

- Alyq
- Tadalafil TABS 20MG
- Tadliq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concurrent use of nitrates.
<b>Required Medical Information</b>	Documentation of New York Heart Association (NYHA) Class II or III.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For Tadliq: documentation of an inability to swallow oral tablets or capsules.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TAKHZYRO

## Products Affected

- Takhzyro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of hereditary angioedema Type 1 and II confirmed by genetic testing or complement studies of C4, C1INH antigenic and C1INH functional levels supporting the diagnosis. For hereditary angioedema Type III, documentation of diagnosis confirmed by genetic testing, normal complement studies combined with clinical features of angioedema or family history. Renewal criteria for long term prevention: Documentation of a reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks or clinical documentation of functional improvement.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, allergist or immunologist.
<b>Coverage Duration</b>	Long term prevention, initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TALTZ

---

## Products Affected

- Taltz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of active nr-axSpA. 3) Psoriatic arthritis renewal: improvement in functioning and/or decreased in number of tender, swollen joints and reduction in skin lesions and/or has disease stability. 4) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, nr-axSpA.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	AS initial: failure of two of the following: adalimumab, Enbrel, Simponi, Cosentyx, Rinvoq, or Xeljanz. All require prior authorization. Nr-axSPA initial: failure of two of the following: adalimumab, Cosentyx, Rinvoq. All require prior authorization. PsA initial: failure of two of the following: adalimumab, Enbrel, Simponi, Orencia, Otezla, Cosentyx, Skyrizi, ustekinumab, Rinvoq, or Xeljanz (IR or XR). All require prior authorization. PsO initial: failure of two of the following: adalimumab, ustekinumab, Enbrel, Otezla, Cosentyx, or Skyrizi. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TARPEYO

---

## Products Affected

- Tarpeyo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of primary immunoglobulin A nephropathy at risk of rapid disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	9 months
<b>Other Criteria</b>	Failure of or intolerance to prednisone.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TAVALISSE

---

## Products Affected

- Tavalisse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of platelet count less than 20,000 per mm <sup>3</sup> or less than 30,000 per mm <sup>3</sup> with symptoms of bleeding. Renewal criteria: Medical record documentation of maintenance of platelet counts of at least 30,000 per mm <sup>3</sup> or an increase in platelet counts from baseline with resolution of bleeding episodes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months
<b>Other Criteria</b>	For chronic immune (idiopathic) thrombocytopenia: documentation of an insufficient response to a previous treatment such as: steroids, IVIG, Promacta, or Rituxan.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TAVNEOS

## Products Affected

- Tavneos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: documentation of microscopic polyangiitis or granulomatosis with polyangiitis, a positive test for anti-PR3 or anti-MPO, documentation that Tavneos will be used in combination with standard therapy (including corticosteroids), and at least 1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria on the Birmingham Vasculitis Activity Score (BVAS). Renewal: Documentation of clinical remission, improved BVAS score or improved functioning and/or symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist or nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TAZORAC

---

## Products Affected

- Tazarotene CREA 0.1%
- Tazarotene GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) For acne vulgaris: documentation of failure of topical tretinoin. 2) For psoriasis vulgaris: documentation of failure of a mid-to-high potency topical corticosteroid (eg. triamcinolone, betamethasone, fluocinonide, or clobetasol) and topical calcipotriene.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TEGSEDI

---

## Products Affected

- Tegsedi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Transthyretin variant by genotyping, documented amyloid deposit by biopsy. Renewal criteria: medical record documentation of improvement in pain or functioning.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TERIFLUNOMIDE

---

## Products Affected

- Teriflunomide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation that teriflunomide is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TERIPARATIDE

## Products Affected

- Bonsity
- Teriparatide

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Patients at increased baseline risk for osteosarcoma (including those with Paget's disease of bone, open epiphyses, or prior external beam or implant radiation therapy involving the skeleton).
<b>Required Medical Information</b>	1) Postmenopausal female with either a) evidence of recent radiographic osteoporotic fracture while on a bisphosphonate or b) high risk or very high risk of osteoporotic fracture. 2) Male with primary or hypogonadal osteoporosis and either a) evidence of history of osteoporotic fracture or b) multiple risk factors for osteoporotic fractures such as BMD less than -2.5 SD, low BMI, history of hip fracture in 1st degree relative, tall stature, and chronic daily use of tobacco. 3) Female or male with steroid-induced osteoporosis and both: a) steroid use for greater than 3 months at a dose of 5mg per day prednisone (or equivalent) and b) BMD T-score less than -2.5. Renewal for all indications: for use longer than 2 years, documentation of high risk of fracture.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Failure of or contraindication to an oral bisphosphonate, unless considered very high risk for fracture.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TETRABENAZINE

## Products Affected

- Tetrabenazine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	1) Tardive dyskinesia and 2) Tourette's Syndrome.
<b>Exclusion Criteria</b>	1) Patients who are actively suicidal or with untreated or inadequately treated depression. 2) Patients with impaired hepatic function. 3) Patients taking monoamine oxidase inhibitors. 4) Patients taking reserpine. At least 20 days should elapse after stopping reserpine before starting tetrabenazine.
<b>Required Medical Information</b>	Initial criteria: If the request is for doses greater than 50 mg per day, medical record documentation of CYP2D6 genotyping is required. Renewal criteria: Medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, and increase in quality of life.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# THALOMID

---

## Products Affected

- Thalomid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Erythema Nodosum Leprosum (ENL) Renewal criteria: documentation of response to treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: hematologist or oncologist for MM, dermatologist for ENL, infectious disease specialist for infection.
<b>Coverage Duration</b>	Cancer: Lifetime. All others: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TICOVAC

---

## Products Affected

- Ticovac

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of planned travel to an endemic country. Renewal for fourth dose: documentation of continued risk after 3 years from initial doses.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 12 months. Renewal: 1 month.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TIGECYCLINE

## Products Affected

- Tigecycline

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Complicated infection of skin and/or subcutaneous tissue: Culture and sensitivity indicates resistance to vancomycin plus aztreonam. 2) Complicated infectious disease of abdomen: Culture and sensitivity indicates resistance to imipenem/cilastin. 3) Community acquired pneumonia: a) Severity of infection necessitates IV treatment and a) Culture and sensitivity indicates resistance to i) a beta-lactam, such as cefotaxime, ceftriaxone plus azithromycin or clarithromycin and ii) fluoroquinolone such as levofloxacin or moxifloxacin.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TIROSINT SOLUTION

---

## Products Affected

- Tirosint-sol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Documentation of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TOCILIZUMAB

## Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Lung disease with systemic sclerosis, renewal: documentation of a reduction in decline in pulmonary function. 3) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Temporal arteritis, renewal: documentation of clinical benefit or remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: pulmonologist for lung disease, rheumatologist for RA, JIA, and temporal arteritis.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	pJIA initial: failure of an 8 week trial of methotrexate.RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

# TOLVAPTAN

## Products Affected

- Tolvaptan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Autosomal dominant polycystic kidney disease, initial: evidence of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD), defined by either a confirmed glomerular filtration rate (GFR) decline of at least 3 mL/min per year over 1 year and/or 2.5 mL/min per year over a period of 5 years OR a total kidney volume increase of at least 5% per year confirmed by at least 3 repeated ultrasound or MRI measurements taken at least 6 months apart.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TOPICAL ANTIVIRALS

---

**Products Affected**

- Acyclovir CREA
- Acyclovir OINT
- Penciclovir CREA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) Applies to acyclovir ointment only: for genital herpes or patient who are immunocompromised with non-life-threatening mucocutaneous herpes simplex infection, failure of oral acyclovir. 2) For penciclovir: for recurrent herpes simplex labialis (oral herpes), failure of topical acyclovir cream.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TOPICAL DICLOFENAC

## Products Affected

- Diclofenac Sodium EXTERNAL SOLN 1.5%
- Diclofenac Sodium GEL 3%

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	1) Cancer-related pain (diclofenac sodium solution only)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For diclofenac 3% gel only: medical record documentation of actinic keratosis. For diclofenac sodium solution: 1) Cancer related pain, initial: medical record documentation of cancer-related pain. 2) Osteoarthritis of the knee, initial: medical record confirmation of osteoarthritis of the knee.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Actinic keratosis: 90 days. All others: 12 months.
<b>Other Criteria</b>	Actinic keratosis, initial: failure of or contraindication to imiquimod and topical 5-fluorouracil.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TOPIRAMATE SOLUTION

---

## Products Affected

- Topiramate SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to new starts only. Initial: Documentation of an inability to swallow oral dosage forms or contents of sprinkle capsules.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TREPROSTINIL

---

## Products Affected

- Treprostinil

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of New York Heart Association (NYHA) Class II to IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or contraindication to 1) sildenafil or tadalafil and 2) bosentan or ambrisentan. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TRIKAFTA

## Products Affected

- Trikafta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Medical record documentation of a diagnosis of cystic fibrosis with at least one F508del mutation or has a mutation that is responsive to the drug confirmed using an FDA-cleared cystic fibrosis mutation test. Renewal criteria: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TRINTELLIX

---

## Products Affected

- Trintellix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of 1) a selective serotonin reuptake inhibitor (SSRI): such as fluoxetine, paroxetine, citalopram, escitalopram, sertraline, AND 2) venlafaxine or duloxetine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TRULICITY

---

## Products Affected

- Trulicity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of type 2 diabetes.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TRUMENBA

---

## Products Affected

- Trumenba

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Between 10 years and 25 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TRYNGOLZA

---

## Products Affected

- Tryngolza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Documentation of a diagnosis of Familial Chylomicronemia Syndrome (FCS) confirmed by a genetic test. Renewal: 1) a reduction in triglycerides from baseline, and 2) documentation of clinical improvement such as episodes of acute pancreatitis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a lipid specialist, endocrinologist, cardiologist, gastroenterologist, or pancreatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# TRYVIO

## Products Affected

- Tryvio

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) blood pressure that is not adequately controlled on multiple blood pressure lowering medications and 2) that Tryvio will be prescribed in combination with other blood pressure lowering medications. Renewal: documentation of reduction in blood pressure from baseline.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, nephrologist or endocrinologist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: Failure of at least two of the following: 1) a beta blocker such as metoprolol, carvedilol, atenolol, 2) a calcium channel blocker such as amlodipine, nifedipine, diltiazem, verapamil, 3) an angiotensin receptor blocker or ACE inhibitor such as losartan or lisinopril, 4) a diuretic such as hydrochlorothiazide.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# TYMLOS

## Products Affected

- Tymlos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Patients at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, or prior external beam or implant radiation therapy involving the skeleton).
<b>Required Medical Information</b>	1) For Postmenopausal females: a) evidence of recent radiographic osteoporotic fracture while on a bisphosphonate or b) high risk or very high risk of osteoporotic fracture. 2) For males: a) documentation of high risk of fracture or b) failure of or intolerance to other osteoporosis therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	24 months. Use is not recommended for longer.
<b>Other Criteria</b>	1) Failure of or contraindication to an oral bisphosphonate, unless considered very high risk for fracture. 2) If there is prior history of a parathyroid hormone analog, cumulative use is not greater than 2 years. If there is prior history then coverage will be allowed to provide a maximum of 24 months of treatment during a lifetime.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# **TYSABRI**

---

## **Products Affected**

- Tysabri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	History of or existing progressive multifocal leukoencephalopathy.
<b>Required Medical Information</b>	Crohn's disease: 1) Baseline CRP greater than 2.87ml/L and 2) if the patient is currently on oral corticosteroids, requires documentation of a steroid taper plan. Renewal criteria for Crohn's disease: documentation of a) reduction in CDAI or number of disease flares and/or improved quality of life, b) If previously on oral steroids, steroid has been successfully discontinued, and c) no history of serious infection or evidence of liver toxicity since the previous authorization. MS renewal: documented benefit since initiation of Tysabri such as delay in the accumulation of physical disability and/or reduction in the frequency of clinical exacerbations and no symptoms suggestive of PML (e.g. progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, and changes in thinking, memory, and orientation leading to confusion and personality changes).
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: gastroenterologist for CD, neurologist for MS.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) Crohn's disease: failure of infliximab and adalimumab. 2) Multiple sclerosis: failure of interferon-beta (Avonex, Rebif, Betaseron), glatiramer, fingolimod or dimethyl fumarate with documentation of all of the following a) continuation of clinical relapses b) CNS lesion progression on MRI or worsening disability and c) documentation that Tysabri is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# UBRELVY

---

## Products Affected

- Ubrelvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of two triptans, such as eletriptan, sumatriptan, naratriptan, rizatriptan, or zolmitriptan, unless there is documentation of intolerance or a contraindication to triptans.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# USTEKINUMAB

---

## Products Affected

- Stelara
- Steqeyma
- Ustekinumab
- Yesintek

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Crohn's Disease (CD) initial: moderate to severe disease activity. CD renewal: medical record documentation of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Psoriasis with arthropathy (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning. 4) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, and/or clinical remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For Stelara only: reason why Yesintek and Steqeyma cannot be used. 1) Plaque psoriasis, initial criteria: failure of a) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization) and b) methotrexate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# UZEDY

---

## Products Affected

- Uzedy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: trial of, intolerance to or contraindication to generic risperidone intramuscular injection (generic Risperdal Consta).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VANRAFIA

## Products Affected

- Vanrafia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: medical record documentation of primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN, b) urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g and c) maximally tolerated dose of a renin-angiotensin system inhibitor (ACE or ARB). Renewal: medical record documentation of a decrease in urine protein-to-creatinine ratio from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VARIZIG

---

## Products Affected

- Varizig INJ 125UNIT/1.2ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VAXCHORA

---

## Products Affected

- Vaxchora

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Medical record documentation of a plan to travel to a cholera-affected area.
<b>Age Restrictions</b>	Between 2 years and 64 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VENTAVIS

---

## Products Affected

- Ventavis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of New York Heart Association (NYHA) Class III to IV.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or contraindication to 1) sildenafil or tadalafil and 2) bosentan or ambrisentan. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VEOZAH

---

## Products Affected

- Veozah

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of moderate to severe vasomotor symptoms due to menopause. Renewal: documentation of a reduction in severity of vasomotor symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	1) Failure of paroxetine. 2) Failure of or contraindication to systemic estrogen.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VERKAZIA

---

## Products Affected

- Verkazia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: documentation of an improvement in symptoms of vernal keratoconjunctivitis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VERQUVO

---

## Products Affected

- Verquvo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of 1) ejection fraction of less than 45%, 2) NYHA class II-IV, 3) a recent decompensation requiring hospitalization or a need for outpatient IV diuretics.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VERSACLOZ

---

## Products Affected

- Versacloz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Documentation of an inability to use clozapine oral disintegrating tablets.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VESICARE LS

---

## Products Affected

- Vesicare Ls

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of neurogenic detrusor overactivity.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VIBERZI

## Products Affected

- Viberzi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic drinks daily. 2) Known or suspected biliary duct obstruction. 3) History of or current chronic or severe constipation. 4) Severe hepatic impairment. 5) Known or suspected mechanical gastrointestinal obstruction. 6) History of pancreatitis. 7) Sphincter of Oddi disease or dysfunction. 8) Structural disease of the pancreas such as pancreatic duct obstruction.
<b>Required Medical Information</b>	Initial: Medical record documentation of irritable bowel syndrome with diarrhea. Documented symptoms of loose or watery stools at least greater than or equal to 25% of stools. Renewal: Medical record documentation of a significant reduction in diarrhea frequency and abdominal pain and/or improvement in quality of life during the 12 week trial.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Renewal: Lifetime.
<b>Other Criteria</b>	Failure of loperamide and dicyclomine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VIGABATRIN

---

## Products Affected

- Vigabatrín
- Vigafyde
- Vigpoder

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Complex Partial Seizures (CPS) Initial: Requires use with another anticonvulsant as combination therapy.
<b>Age Restrictions</b>	Infantile Spasm: 2 years of age or younger
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug for the treatment of Complex Partial Seizures: Failure of adjunctive treatment with at least two of the following: topiramate, felbamate, gabapentin, lamotrigine, tiagabine, levetiracetam, oxcarbazepine, zonisamide or lacosamide.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VIIBRYD

## Products Affected

- Vilazodone Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concomitant use of a MAOI or within 14 days after discontinuing a MAOI.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Documentation of failure of 1) a selective serotonin reuptake inhibitor such as paroxetine, fluoxetine, citalopram, escitalopram or sertraline and 2) venlafaxine or duloxetine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VIJOICE

## Products Affected

- Vioice

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: a) medical record documentation of a mutation in the PIK3CA gene. b) documentation of the need for systemic therapy. Renewal: documentation of a reduction in lesion size or significant improvement in symptoms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a genetic specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOQUEZNA PAK

---

**Products Affected**

- Voquezna Dual Pak
- Voquezna Triple Pak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Confirmation of active helicobacter pylori infection via diagnostic testing such as biopsy, urea breath test, or stool antigen assay.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	Documentation of failure of or high likelihood of resistance to a) rifabutin triple therapy (rifabutin, amoxicillin and a proton pump inhibitor) or b) bismuth quadruple therapy (bismuth salicylate, metronidazole, tetracycline and a proton pump inhibitor).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VORICONAZOLE

---

## Products Affected

- Voriconazole INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, hematologist or oncologist.
<b>Coverage Duration</b>	Until end of plan year
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOSEVI

## Products Affected

- Vosevi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder) with a NS5A inhibitor for genotype 1 to 6 and/or sofosbuvir without an NS5A inhibitor for genotype 1a and genotype 3 and 3) Documentation of presence or absence of cirrhosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOWST

---

## Products Affected

- Vowst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Documentation of at least 1 recurrent episode of c. difficile infection (CDI) with a positive stool test and 2) documentation that Vowst will be initiated withing 2-4 days following completion of an antibiotic course of treatment for CDI.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOXZOGO

---

## Products Affected

- Voxzogo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) diagnosis of achondroplasia confirmed by genetic testing with a mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene, and 2) open epiphyses. Renewal: medical record documentation of open epiphyses.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOYDEYA

---

## Products Affected

- Voydeya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: confirmation of a diagnosis of paroxysmal nocturnal hemoglobinuria via flow cytometry. Renewal criteria: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or an oncologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VOYXACT

## Products Affected

- Voyxact

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN, b) laboratory results confirming proteinuria, and c) on maximally tolerated dose of a renin-angiotensin system inhibitor (ACE or ARB), unless there is intolerance or contraindication. IgAN Renewal: medical record documentation of clinical benefit, such as a decrease in urine protein-to-creatinine ratio from baseline.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# VPRIV

## Products Affected

- Vpriv

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) Diagnosis confirmed by one of the following: a) biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity, b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene. 2) Severity of disease results in one or more of the following conditions: a) moderate to severe anemia, b) thrombocytopenia with bleeding tendency, c) bone disease, d) significant hepatomegaly or splenomegaly. 3) Objective, measurable treatment goals are provided. Renewal: 1) Medical record documentation of stabilization of disease progression, such as a) improvement in hematologic markers, such as increased hgb/hct and/or platelet counts, b) reduction in spleen or liver volume, c) reduction in biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), d) reduction in skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
<b>Age Restrictions</b>	4 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Dosing consistent with product label: 60 units/kg every other week. Range 15-60 units/kg.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VYNDAQEL

---

**Products Affected**

- Vyndamax
- Vyndaqel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation confirming the diagnosis of either wild-type or hereditary transthyretin amyloid cardiomyopathy (ATTRwt-CM or hATTR-CM).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# VYVGART HYTRULO

## Products Affected

- Vyvgart Hytrulo INJ 1000MG/5ML; 10000UNIT/5ML

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Generalized myasthenia gravis (gMG): initial: medical record confirmation of anti-acetylcholine receptor (AChR) antibody positive status. Renewal, medical record documentation of a clinical response to Vyvgart Hytrulo, such as improvement in functioning. 2) Chronic inflammatory demyelinating polyneuropathy (CIDP): medical record confirmation of a diagnosis of CIDP. Renewal: medical record documentation of a clinical response to Vyvgart Hytrulo, such as improvement from baseline strength or weakness.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	1) gMG, initial: failure of a) an oral immunosuppressant such as azathioprine, mycophenolate, cyclosporine or tacrolimus, and b) intravenous immune globulin. 2) CIDP, initial: failure of intravenous immune globulin.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# WAINUA

---

## Products Affected

- Wainua

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: medical record documentation of genetic mutation in the TTR gene and Stage 1 or 2 familial amyloid polyneuropathy (FAP). Renewal: documentation of improvement in pain or functioning.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# WAKIX

## Products Affected

- Wakix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a sleep medicine specialist or neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: Lifetime.
<b>Other Criteria</b>	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# WAYRILZ

## Products Affected

- Wayrilz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) insufficient response to previous treatment such as oral corticosteroids, IVIG (requires prior authorization) or splenectomy and 2) platelet count less than 30,000 per mm <sup>3</sup> . Renewal: Medical record documentation of maintenance of platelet counts between 30,000 per mm <sup>3</sup> and 150,000 per mm <sup>3</sup> or an increase in platelet counts from baseline with resolution of bleeding episodes.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Initial: Failure of eltrombopag (requires prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# WINREVAIR

---

## Products Affected

- Winrevair

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Documentation of WHO Group 1 pulmonary arterial hypertension diagnosed by right heart catheterization. Renewal: Documentation of clinical improvement or disease stability such as increased exercise capacity, improvement in WHO functional class, or decreased clinical worsening events.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Initial: 12 months. Renewal: Lifetime.
<b>Other Criteria</b>	Trial of or contraindication to: 1) sildenafil or tadalafil and 2) bosentan, ambrisentan or macitentan. All require prior authorization.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# WYOST

## Products Affected

- Wyost

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Preexisting hypocalcemia and pregnancy.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) For bone metastasis associated with solid tumors and prevention of skeletal related events in patients with multiple myeloma: documentation of failure of zoledronic acid or there is a contraindication to zoledronic acid that is not a contraindication to denosumab. 2) For the treatment of hypercalcemia of malignancy: failure of one IV bisphosphonate including zoledronic acid or pamidronate.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# XCOPRI

---

## Products Affected

- Xcopri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: Failure of two of the following: carbamazepine, oxcarbazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, lacosamide and levetiracetam.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# XDEMZY

## Products Affected

- Xdemzy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record confirmation of blepharitis caused by demodex mites.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an optometrist or ophthalmologist.
<b>Coverage Duration</b>	6 weeks
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# XELJANZ

---

## **Products Affected**

- Xeljanz
- Xeljanz Xr

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Ankylosing spondylitis (AS) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. AS renewal: improvement in functioning and/or improvement in signs and symptoms of AS. 2) Polyarticular juvenile idiopathic arthritis (pJIA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. pJIA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 3) Psoriatic arthritis (PsA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. PsA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Rheumatoid arthritis (RA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. RA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 5) Ulcerative Colitis (UC) initial: a) moderate to severe disease activity and b) documentation of an inadequate response or intolerance to at least one TNF inhibitor. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, gastroenterologist for UC, rheumatologist for RA, pJIA and AS.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	For oral solution only: documentation of an inability to swallow solid oral dosage forms, or documentation that the tablets are not indicated for the member's age. 1) AS initial: failure of one oral nonsteroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. pJIA initial: failure of an 8 week trial of methotrexate. RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# XERMELO

## Products Affected

- Xermelo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Carcinoid syndrome initial: a) Four or more daily bowel movements despite the use of a somatostatin analog such as octreotide for at least 3 months and b) concurrent use of a somatostatin analog. Renewal: documentation of clinical response to therapy defined as a reduction from baseline in bowel movement frequency.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# XGEVA

## Products Affected

- Xgeva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Preexisting hypocalcemia and pregnancy.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	1) For bone metastasis associated with solid tumors and prevention of skeletal related events in patients with multiple myeloma: documentation of failure of zoledronic acid or there is a contraindication to zoledronic acid that is not a contraindication to denosumab. 2) For the treatment of hypercalcemia of malignancy: failure of one IV bisphosphonate including zoledronic acid or pamidronate. 3) Prerequisite therapy is not required for giant cell tumor of bone.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# **XOLAIR**

---

## **Products Affected**

- Xolair

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	1) Allergic asthma initial: a) positive skin prick test or in-vitro specific IgE test (such as RAST, MAST, FAST, ELISA) to one or more perennial allergens, b) total serum IgE of 30 -1,300 IU/mL for pediatric patients age 6 to less than 12 years of age or 30 -700 IU/ml for age 12 and above, c) documentation supporting poor asthma control such as multiple asthma exacerbations resulting in repeated uses of health care services including urgent care, ED visits or hospitalizations and/or limitation in activities of daily living. Asthma renewal: reduction in asthma exacerbations and frequency of office visits, ED or urgent care visits, hospitalizations and in the use/need for oral steroids and sustained clinical improvement from baseline. 2) Chronic idiopathic urticaria (CIU) initial: medical record documentation of urticaria for 6 weeks or longer. CIU renewal: documentation of clinical response to Xolair. 3) Nasal polyps (NP) initial: a) documentation that Xolair is being used as add-on therapy, and b) documentation of an inadequate response to nasal corticosteroids. NP renewal: Documentation of clinical benefit from Xolair. 4) IgE-mediated food allergy initial: medical documentation or laboratory result confirmation of: a) IgE-mediate food allergy, b) allergic reaction to one more foods, and c) that Xolair will be used in conjunction with food allergen avoidance. IgE-mediated food allergy renewal: Xolair continues to be used in conjunction with food allergen avoidance.
<b>Age Restrictions</b>	Allergic asthma: 6 years of age or older. Chronic idiopathic urticaria: 12 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for allergic asthma, allergist, immunologist or dermatologist for chronic idiopathic urticaria, allergist or immunologist for IgE-mediated food allergy.
<b>Coverage Duration</b>	Initial: 6 months. Asthma, NP, IgE allergy renewal: 12 months. CIU renewal: lifetime.
<b>Other Criteria</b>	1) For the treatment of allergic asthma: failure of, intolerance to or contraindication to a high-dose inhaled corticosteroid and a long-acting beta agonist. 2) For the treatment of chronic idiopathic urticaria: failure of, intolerance to or contraindication to a second-generation

	antihistamines for at least two weeks (failure defined as continued hives and itching).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# XOLREMDI

## Products Affected

- Xolremdi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) medical record documentation of a diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome, confirmed by molecular genetic testing or a bone marrow biopsy. 2) baseline absolute neutrophil count and absolute lymphocyte count. Renewal: medical record documentation of an increase in absolute neutrophil count and absolute lymphocyte count from baseline.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, immunologist or dermatologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# XROMI

---

## Products Affected

- Xromi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of sickle cell anemia with crisis.
<b>Age Restrictions</b>	6 months of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	For patients age 18 years and older: documentation of an inability to swallow solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# XURIDEN

## Products Affected

- Xuriden

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Genetic testing indicating a deficiency in uridine 5'-monophosphate (UMP) synthase or above normal urine concentration of orotic acid. Renewal: evidence of hematologic improvements.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or metabolic disorder specialist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# XYREM

## Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	1) Succinic semialdehyde dehydrogenase deficiency. 2) Concurrent treatment with sedative hypnotics.
<b>Required Medical Information</b>	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a sleep medicine specialist or neurologist.
<b>Coverage Duration</b>	Initial: 3 months. Renewal: Lifetime.
<b>Other Criteria</b>	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require PA).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# XYWAV

---

## Products Affected

- Xywav

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a sleep medicine specialist.
<b>Coverage Duration</b>	Initial: 3 months. Renewal: Lifetime.
<b>Other Criteria</b>	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy or idiopathic hypersomnia): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require PA).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# YORVIPATH

---

## Products Affected

- Yorvipath

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial criteria: Prior to initiation of therapy, 25-hydroxyvitamin D stores is within normal range and serum calcium (albumin adjusted) greater than or equal to 7.8 mg/dL. Renewal criteria: maintenance of serum calcium (albumin-corrected) concentration in the low-normal range.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or nephrologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# YUTREPIA

## Products Affected

- Yutrepia

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Confirmation of a diagnosis of pulmonary arterial hypertension (PAH) WHO group 1 via right heart catheterization with NYHA FC III symptoms, or pulmonary hypertension associated with interstitial lung disease (PH-ILD) WHO Group 3.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	Failure of or contraindication to 1) sildenafil or tadalafil (both require prior authorization) and 2) bosentan or ambrisentan (both require prior authorization).
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ZAVESCA

## Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record documentation of 1) diagnostic conformation by biochemical assay of decreased glucocerebrosidase activity in WBCs or skin fibroblasts, or genotyping revealing two pathogenic mutations of the glucocerebrosidase gene, and 2) Hgb at least 9g/dL and platelet at least 50 x10 <sup>9</sup> /L. Renewal: Medical record documentation of stabilization of disease progression such as 1) Improvement in hematologic markers such as increased Hgb/Hct and/or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Dosing consistent with product label: 100mg up to three times a day.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZELSUVMI

---

## Products Affected

- Zelsuvmi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of diagnosis of molluscum contagiosum.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	For patients 2 years of age or older: Failure of Ycanth.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

## ZEMAIRA/PROLASTIN

### Products Affected

- Prolastin-c INJ 1000MG/20ML
- Zemaira

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: 1) documented ZZ or Z/null AAT deficiency and 2) AAT serum level less than or equal to 11 micromoles/L or 50mg/dL and 3) moderate emphysema and/or FEV1 less than 80% and 4) the provider has outlined specific, measurable treatment goals such as slowing of FEV1 decline or lack of disease progression. Renewal: documentation patient is meeting treatment goals such as slowing FEV1 decline or lack of disease progression.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Initial: Medical record documentation of failure of or intolerance to Aralast or reason why Aralast cannot be used.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ZILBRYSQ

---

## Products Affected

- Zilbrysq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Medical record confirmation of a diagnosis of generalized myasthenia gravis (gMG) and anti-acetylcholine receptor (AChR) antibody positive status. Renewal: medical record documentation of a clinical response, such as improvement in function.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months.
<b>Other Criteria</b>	Failure of 1) pyridostigmine, and 2) an immunomodulator such as azathioprine, mycophenolate or cyclosporine.
<b>Prerequisite Therapy Required</b>	Criteria DOES require use of a prerequisite Part D drug.

# ZINPLAVA

---

## Products Affected

- Zinplava

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Evidence that the patient is currently using standard antibacterial drug treatment according to the FDA approved label.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	180 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZOKINVY

---

## Products Affected

- Zokinvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of Hutchinson-Gilford progeria syndrome (HGPS), or processing-deficient progeroid laminopathies (PLs) confirmed by genetic testing.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist or metabolic disorder specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZONISADE

---

## Products Affected

- Zonisade

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	The following criteria applies to members who newly start on the drug: documentation of an inability to take solid oral dosage forms.
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZTALMY

---

## Products Affected

- Ztalmy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug: Medical record documentation confirming a diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZURZUVAE

---

## Products Affected

- Zurzuvae

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Current pregnancy.
<b>Required Medical Information</b>	Medical record documentation of a diagnosis of postpartum depression.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

# ZYPREXA RELPREVV

---

## Products Affected

- Zyprexa Relprevv

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The following criteria applies to members who newly start on the drug: currently taking oral olanzapine and prescriber wishes to switch to the injection to improve compliance.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Lifetime
<b>Other Criteria</b>	N/A
<b>Prerequisite Therapy Required</b>	Criteria DOES NOT require use of a prerequisite Part D drug.

## **PART B VERSUS PART D**

---

### **Products Affected**

- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%,  
0.63MG/3ML, 1.25MG/3ML,  
2.5MG/0.5ML
- Aminosyn II INJ 107.6MEQ/L;  
1490MG/100ML; 1527MG/100ML;  
1050MG/100ML; 1107MG/100ML;  
750MG/100ML; 450MG/100ML;  
990MG/100ML; 1500MG/100ML;  
1575MG/100ML; 258MG/100ML;  
405MG/100ML; 447MG/100ML;  
1083MG/100ML; 795MG/100ML;  
50MEQ/L; 600MG/100ML;  
300MG/100ML; 750MG/100ML,  
993MG/100ML; 1018MG/100ML;  
700MG/100ML; 738MG/100ML;  
500MG/100ML; 300MG/100ML;  
660MG/100ML; 1000MG/100ML;  
1050MG/100ML; 172MG/100ML;  
270MG/100ML; 298MG/100ML;  
722MG/100ML; 530MG/100ML;  
400MG/100ML; 200MG/100ML;  
500MG/100ML
- Aminosyn-pf INJ 46MEQ/L;  
698MG/100ML; 1227MG/100ML;  
527MG/100ML; 820MG/100ML;  
385MG/100ML; 312MG/100ML;  
760MG/100ML; 1200MG/100ML;  
677MG/100ML; 180MG/100ML;  
427MG/100ML; 812MG/100ML;  
495MG/100ML; 70MG/100ML;  
512MG/100ML; 180MG/100ML;  
44MG/100ML; 673MG/100ML
- Aminosyn-pf 7% INJ 32.5MEQ/L;  
490MG/100ML; 861MG/100ML;  
370MG/100ML; 576MG/100ML;  
270MG/100ML; 220MG/100ML;  
534MG/100ML; 831MG/100ML;  
475MG/100ML; 125MG/100ML;  
300MG/100ML; 570MG/100ML;  
347MG/100ML; 50MG/100ML;  
360MG/100ML; 125MG/100ML;  
44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Amphotericin B Liposome

- Arformoterol Tartrate
- Azathioprine INJ
- Azathioprine TABS
- Budesonide SUSP
- Cladribine INJ
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix E 2.75%/dextrose 5% INJ  
570MG/100ML; 316MG/100ML;  
33MG/100ML; 5GM/100ML;  
515MG/100ML; 132MG/100ML;  
165MG/100ML; 201MG/100ML;  
159MG/100ML; 51MG/100ML;  
110MG/100ML; 454MG/100ML;  
154MG/100ML; 261MG/100ML;  
187MG/100ML; 138MG/100ML;  
217MG/100ML; 112MG/100ML;  
116MG/100ML; 50MG/100ML;  
11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified CAPS 100MG,  
50MG
- Cyclosporine Modified SOLN
- Cytarabine INJ 100MG/ML,  
20MG/ML
- Cytarabine Aqueous
- Depo-medrol INJ 20MG/ML
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG,  
0.75MG, 1MG
- Ganciclovir INJ 500MG
- Gengraf CAPS 100MG
- Gengraf SOLN

- Hepelisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride
- Methylprednisolone TABS
- Methylprednisolone Sodium Succinate
- Methylprednisolone Sodiumsuccinate INJ 40MG
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myhibbin
- Nutrilipid
- Plenamine INJ 147.4MEQ/L;  
2.17GM/100ML; 1.47GM/100ML;  
434MG/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
749MG/100ML; 1.04GM/100ML;  
1.18GM/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
592MG/100ML; 749MG/100ML;  
250MG/100ML; 39MG/100ML;  
960MG/100ML
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG,  
2.5MG, 20MG, 50MG, 5MG
- Prehevbrio
- Premasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 356MG/100ML;  
390MG/100ML; 34MG/100ML;  
152MG/100ML
- Prograf PACK
- Prosol

- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU 300MG/5ML
- Travasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 500MG/100ML;  
356MG/100ML; 390MG/100ML;  
34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML;  
1.2GM/100ML; 0.32GM/100ML; 0; 0;  
0.5GM/100ML; 0.36GM/100ML;  
0.48GM/100ML; 0.82GM/100ML;  
1.4GM/100ML; 1.2GM/100ML;  
0.34GM/100ML; 0.48GM/100ML;  
0.68GM/100ML; 0.38GM/100ML;  
5MEQ/L; 0.025GM/100ML;  
0.42GM/100ML; 0.2GM/100ML;  
0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML

## Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

# INDEX

## A

Abilify Mycite .....	1	Ambrisentan .....	13
Abilify Mycite Maintenance Kit .....	1	Aminosyn II .....	389
Abilify Mycite Starter Kit .....	1	Aminosyn-pf .....	389
Abiraterone Acetate .....	39	Aminosyn-pf 7% .....	389
Abirtega .....	39	Amnesteem .....	142
Abraxane .....	39	Amphotericin B .....	389
Accutane .....	142	Amphotericin B Liposome .....	389
Acetylcysteine .....	389	Anzupgo .....	14
Actemra .....	317	Apomorphine .....	15
Actemra Actpen .....	317	Apomorphine Hydrochloride .....	15
Acthar .....	2	Aprepitant .....	16
Acthar Hp .....	2	Aqneursa .....	17
Actimmune .....	4	Aralast .....	18
Acyclovir .....	319	Aralast Np .....	18
Acyclovir Sodium .....	389	Arcalyst .....	19
Adalimumab .....	5	Arexvy .....	261
Adalimumab-aaty 1-pen Kit .....	5	Arformoterol Tartrate .....	389
Adalimumab-aaty 2-pen Kit .....	5	Arikayce .....	20
Adalimumab-aaty 2-syringe .....	5	Aristada .....	21
Adalimumab-aaty Cd/uc/hs Starter .....	5	Aristada Initio .....	21
Adalimumab-adbm .....	5	Armodafinil .....	22
Adbry .....	7	Astagraf .....	23
Adempas .....	255	Astagraf XL .....	23
Agamree .....	8	Atgam .....	137
Aimovig .....	9	Attruby .....	24
Akeega .....	39	Augtyro .....	39
Albuterol Sulfate .....	389	Austedo .....	25
Alcohol Prep Pads .....	136	Auvelity .....	26
Aldurazyme .....	10	Avastin .....	39
Alecensa .....	39	Avmapki Fakzyna Co-pack .....	39
Aliqopa .....	39	Avsola .....	132
Alosetron .....	11	Ayvakit .....	39
Alosetron Hydrochloride .....	11	Azathioprine .....	389
Alunbrig .....	39		
Alyftrek .....	12	<b>B</b>	
Alyq .....	301	Balversa .....	39
		Bavencio .....	39
		Bd Autosshield Duo 30g X 5mm .....	136

Bd Insulin Syringe Safetyglide/1ml/29g X 1/2 .	136
B-d Insulin Syringe Ultrafine Ii/0.3ml/31g X 5/16	136
Bd Insulin Syringe Ultra-fine/0.5ml/30g X 12.7mm.....	136
Bd Insulin Syringe Ultra-fine/1ml/31g X 8mm	136
Bd Pen Needle/original/ultra-fine/29g X 12.7mm	136
Beleodaq.....	39
Bempedoic Acid.....	27
Bendamustine Hydrochloride.....	39
Benlysta.....	28
Benznidazole.....	29
Besremi.....	39
Betaine Anhydrous.....	66
Bexarotene.....	39
Bexsero.....	30
Bivigam.....	137
Bonsity.....	311
Bortezomib.....	39
Bosentan.....	31
Bosulif.....	39
Botox.....	32
Botulinum Toxins.....	32
Braftovi.....	39
Brinsupri.....	33
Briviact.....	34
Bronchitol.....	35
Brukinsa.....	39
Budesonide.....	389
Buprenorphine.....	36
Buprenorphine Patch.....	36
Busulfan.....	39
<b>C</b>	
Cablivi.....	37
Cabometyx.....	39
Calquence.....	39
Camzyos.....	38
Cancer Drugs.....	39
Caplyta.....	43
Caprelsa.....	39
Carbaglu.....	44

Carglumic Acid.....	44
Carmustine.....	39
Cayston.....	45
Cerdelga.....	46
Cerezyme.....	47
Chenodal.....	48
Cholbam.....	49
Cimzia.....	50
Cimzia Starter Kit.....	50
Citalopram 40mg.....	52
Citalopram Hydrobromide.....	52
Cladribine.....	389
Claravis.....	142
Clinimix 4.25%/dextrose 10%.....	389
Clinimix 4.25%/dextrose 5%.....	389
Clinimix 5%/dextrose 15%.....	389
Clinimix 5%/dextrose 20%.....	389
Clinimix E 2.75%/dextrose 5%.....	389
Clinimix E 4.25%/dextrose 10%.....	389
Clinimix E 4.25%/dextrose 5%.....	389
Clinimix E 5%/dextrose 15%.....	389
Clinimix E 5%/dextrose 20%.....	389
Clinisol Sf 15%.....	389
Clinolipid.....	389
Clobazam.....	53
Clofarabine.....	39
Cobenfy.....	54
Cobenfy Starter Pack.....	54
Colony Stimulating Factors.....	55
Cometriq.....	39
Copiktra.....	39
Corlanor.....	56
Cortrophin.....	2, 57
Cosentyx.....	59
Cosentyx Sensoready Pen.....	59
Cosentyx Unoready.....	59
Cotellic.....	39
Crenessity.....	61
Cresemba.....	62
Crisaborole.....	63
Cromolyn Sodium.....	389
Ctexli.....	64
Curity Gauze Pads 2.....	136

Cuvrior .....	65
Cyclophosphamide .....	389
Cyclosporine .....	390
Cyclosporine Modified.....	390
Cyramza .....	39
Cystadane .....	66
Cystadrops.....	67
Cystaran.....	67
Cysteamine .....	67
Cytarabine .....	390
Cytarabine Aqueous .....	390

## **D**

Dactinomycin .....	39
Dalfampridine .....	68
Dalfampridine Er.....	68
Danziten .....	39
Darzalex .....	39
Darzalex Faspro .....	39
Dasatinib .....	39
Daurismo .....	39
Dawnzera.....	69
Daybue .....	70
Deferasirox .....	141
Deferiprone .....	141
Deflazacort .....	71
Dengvaxia .....	72
Depo-medrol .....	390
Diacomit.....	73
Dichlorphenamide .....	148
Diclofenac Sodium.....	320
Dificid .....	74
Docetaxel.....	39
Dojolvi.....	75
Doptelet.....	76
Doptelet Sprinkle .....	77
Drizalma .....	78
Drizalma Sprinkle .....	78
Dronabinol.....	79
Droxidopa.....	80
Dupixent.....	81
Duvezat .....	83

## **E**

Egrifta .....	84
Egrifta Sv .....	84
Ekterly.....	85
Elaprase.....	86
Eligard.....	154
Eliquis .....	87
Elmiron .....	228
Eltrombopag.....	88
Eltrombopag Olamine.....	88
Emend .....	16
Emgality .....	89
Empaveli .....	90
Empliciti.....	39
Emsam.....	91
Emverm.....	170
Enbrel.....	92
Enbrel Mini .....	92
Enbrel Sureclick.....	92
Endaravone .....	94
Endari.....	95
Engerix-b.....	390
Ensacove .....	39
Enspryng .....	96
Entyvio.....	97
Entyvio Pen.....	97
Eohilia .....	98
Epclusa.....	281
Epidiolex .....	99
Erbitux.....	39
Eribulin Mesylate.....	39
Erivedge .....	39
Erleada .....	39
Erlotinib Hydrochloride .....	39
Erythropoiesis-stimulating Agents.....	100
Eslicarbazepine .....	101
Eslicarbazepine Acetate .....	101
Eucrisa.....	63
Evenity .....	102
Everolimus .....	39, 390
Evrysdi .....	103
Exkivity.....	39
Exondys.....	104

Exondys 51 .....	104
Exxua.....	105
Exxua Titration Pack.....	105

**F**

Fabhalta .....	106
Fabrazyme .....	107
Fasenra .....	108
Fasenra Pen .....	108
Fentanyl Citrate Oral Transmucosal .....	204
Ferriprox.....	141
Fetzima .....	109
Fetzima Titration Pack .....	109
Fidaxomicin.....	110
Filspari.....	111
Filsuvez .....	112
Fingolimod .....	113
Fingolimod Hydrochloride.....	113
Fintepla.....	114
Firdapse .....	115
Firmagon .....	39
Flebogamma Dif.....	137
Fluorouracil.....	39
Folotyng .....	39
Fosrenol.....	153
Fotivda.....	39
Fruzaqla.....	39
Fulphila .....	55
Fulvestrant.....	39

**G**

Galafold.....	116
Gamastan.....	137
Gammagard Liquid .....	137
Gammagard Liquid Erc.....	137
Gammagard S/d Iga Less Than 1mcg/ml.....	137
Gammaked .....	137
Gammaplex .....	137
Gamunex-c .....	137
Ganciclovir .....	390
Gardasil .....	117
Gardasil 9 .....	117
Gattex .....	118

Gavreto.....	39
Gefitinib .....	39
Gemtesa.....	119
Gengraf .....	390
Genotropin .....	284
Genotropin Miniquick.....	284
Gilotrif.....	39
Glycerol Phenylbutyrate .....	120
Gomekli.....	39
Granisetron.....	121
Granisetron Hcl.....	121
Granisetron Hydrochloride .....	121
Granix .....	55
Grastek .....	202

**H**

Haegarda .....	122
Heplisav-b.....	390
Hernexeos .....	39
Hetlioz.....	123
Hetlioz Lq .....	123
Humatrope.....	284
Humira .....	5
Humira Pediatric Crohns Disease Starter Pack.....	5
Humira Pen .....	5
Humira Pen-cd/uc/hs Starter .....	5
Humira Pen-pediatric Uc Starter Pack.....	5
Humira Pen-ps/uv Starter.....	5
Hyftor .....	124
Hyrnuo .....	39

**I**

Ibrance.....	39
Ibtrozi .....	125
Icatibant.....	126
Icatibant Acetate .....	126
Iclusig.....	39
Idarubicin Hcl .....	39
Idarubicin Hydrochloride.....	39
Idhifa .....	39
Imatinib Mesylate .....	39
Imbruvica .....	39, 127
Imbruvica 140mg Tablets .....	127

Imfinzi .....	39
Imkeldi .....	128
Imovax Rabies (h.d.c.v.) .....	390
Impavido .....	129
Inbrija .....	130
Increlex .....	131
Inflectra .....	132
Infliximab .....	132
Ingrezza .....	134
Inluriyo .....	39
Inlyta .....	39
Inqovi .....	39
Inrebic .....	135
Insulin Administration Supplies .....	136
Intralipid .....	390
Intravenous Immune Globulin .....	137
Invega Hafyera .....	218
Invega Trinza .....	218
Ipratropium Bromide .....	390
Ipratropium Bromide/albuterol Sulfate .....	390
Iqirvo .....	140
Iron Chelating Agents .....	141
Isotretinoin .....	142
Itovebi .....	40
Ivabradine Hydrochloride .....	56
Iwilfin .....	40

## **J**

Jakafi .....	40
Jaypirca .....	40
Jaythari .....	71
Jevtana .....	40
Joenja .....	143
Journavx .....	144
Juxtapid .....	145
Jylamvo .....	172

## **K**

Kalydeco .....	146
Kerendia .....	147
Keveyis .....	148
Keytruda .....	40
Kineret .....	149

Kisqali .....	40
Kisqali Femara 200 Dose .....	40
Kisqali Femara 400 Dose .....	40
Kisqali Femara 600 Dose .....	40
Korlym .....	150
Koselugo .....	40, 151
Koselugo Granule .....	151
Krazati .....	40
Kymbee .....	71
Kyprolis .....	40

## **L**

Lampit .....	152
Lanreotide Acetate .....	286
Lanthanum .....	153
Lanthanum Carbonate .....	153
Lapatinib Ditosylate .....	40
Lazcluze .....	40
Lenalidomide .....	40
Lenvima 10 Mg Daily Dose .....	40
Lenvima 12mg Daily Dose .....	40
Lenvima 14 Mg Daily Dose .....	40
Lenvima 18 Mg Daily Dose .....	40
Lenvima 20 Mg Daily Dose .....	40
Lenvima 24 Mg Daily Dose .....	40
Lenvima 4 Mg Daily Dose .....	40
Lenvima 8 Mg Daily Dose .....	40
Leukine .....	55
Leuprolide .....	154
Leuprolide Acetate .....	154
Levalbuterol .....	390
Levalbuterol Hcl .....	390
Levalbuterol Hydrochloride .....	390
Levetiracetam .....	290
Levoleucovorin .....	155
Levoleucovorin Calcium .....	155
L-glutamine .....	95
Libtayo .....	40
Lidocaine .....	156
Lidocaine Patch .....	156
Liraglutide .....	157
Lisdexamfetamine .....	158
Lisdexamfetamine Dimesylate .....	158

Lithium .....	159
Lithium Solution .....	159
Livdelzi .....	160
Livmarli .....	161
Livtency .....	162
Lodoco .....	163
Lofexidine Hydrochloride .....	164
Lokelma .....	234
Lonsurf .....	40
Lorbrena .....	40
Lucemyra .....	164
Lumakras .....	40
Lumizyme .....	165
Lupkynis .....	166
Lupron Depot (1-month) .....	154
Lupron Depot (3-month) .....	154
Lupron Depot (4-month) .....	154
Lupron Depot (6-month) .....	154
Lupron Depot-ped (1-month) .....	154
Lupron Depot-ped (3-month) .....	154
Lybalvi .....	167
Lynparza .....	40
Lytgobi .....	40

## **M**

Mavyret .....	168
Mayzent .....	169
Mayzent Starter Pack .....	169
Mebendazole .....	170
Mekinist .....	40
Mektovi .....	40
Melphalan Hydrochloride .....	40
Mercaptopurine .....	171
Mercaptopurine Suspension .....	171
Methitest .....	299
Methotrexate Solution .....	172
Methylprednisolone .....	390
Methylprednisolone Sodium Succinate .....	390
Methylprednisolone Sodumsuccinate .....	390
Metyrosine .....	173
Mifepristone .....	150
Miglustat .....	379
Miplyffa .....	174

Mitomycin .....	40
Modafinil .....	175
Modeyso .....	40
Motegrity .....	176
Mounjaro .....	177
Movantik .....	178
Mulpleta .....	179
Multaq .....	180
Mutamycin .....	40
Myalept .....	181
Mycapssa .....	182
Mycophenolate Mofetil .....	390
Mycophenolic Acid Dr .....	390
Myfembree .....	183
Myhibbin .....	390
Mylotarg .....	40

## **N**

Naglazyme .....	184
Nelarabine .....	40
Nerlynx .....	185
Neulasta .....	55
Nexletol .....	27
Nexlizet .....	27
Nilotinib Hydrochloride .....	40
Ninlaro .....	40
Nintedanib Esylate .....	240
Nipent .....	40
Nitazoxanide .....	186
Nitisinone .....	207
Nityr .....	187
Norditropin Flexpro .....	284
Noxafil .....	233
Nubeqa .....	40
Nucala .....	188
Nuedexta .....	190
Nulojix .....	191
Nuplazid .....	192
Nurtec .....	193
Nutrilipid .....	390
Nutropin Aq Nuspin 10 .....	284
Nutropin Aq Nuspin 20 .....	284
Nutropin Aq Nuspin 5 .....	284

**O**

Ocaliva .....	194
Ocrevus .....	195
Ocrevus Zunovo .....	195
Octagam .....	137
Octreotide Acetate.....	265
Odactra .....	202
Odomzo .....	40
Ofev.....	240
Ogsiveo .....	40
Ojemda .....	40
Ojjaara .....	40
Omnipod.....	196
Omnipod 5 Dexcom G7g6 Intro Kit (gen 5).....	196
Omnipod 5 Dexcom G7g6 Pods (gen 5).....	196
Omnipod 5 G7 Intro Kit (gen 5) .....	196
Omnipod 5 G7 Pods (gen 5).....	196
Omnipod 5 Libre2 Plus G6 Intro Gen 5.....	196
Omnipod 5 Libre2 Plus G6 Pods .....	196
Omnipod Classic Pods (gen 3).....	196
Omnipod Dash Intro Kit (gen 4).....	196
Omnipod Dash Pdm Kit (gen 4).....	196
Omnipod Dash Pods (gen 4) .....	196
Omnitrope .....	284
Onureg.....	40
Opdivo.....	40
Opfolda.....	198
Opipza .....	199
Opium.....	200
Opium Tincture .....	200
Opsumit.....	201
Oral Immunotherapy .....	202
Oral Ribavirin.....	203
Oral Transmucosal Fentanyl .....	204
Orencia .....	205
Orencia Clickject.....	205
Orenitram .....	206
Orenitram Titration Kit Month 1.....	206
Orenitram Titration Kit Month 2.....	206
Orenitram Titration Kit Month 3.....	206
Orfadin .....	207
Orgovyx.....	208
Oriahnn.....	209

Orilissa .....	210
Orkambi .....	211
Orserdu.....	40
Osenvelt .....	212
Otezla .....	213
Otezla Xr.....	213
Otezla/otezla Xr 28 Day Treatment Initiation Pack .....	213
Overactive Bladder Drugs.....	214
Oxervate.....	215
Oxybutynin Chloride .....	214
Oxybutynin Chloride Er.....	214
Oxycodone Extended Release.....	216
Oxycodone Hydrochloride Er.....	216
Oxycontin.....	216
Ozempic .....	217

**P**

Paclitaxel Protein-bound Particles .....	40
Paliperidone Extended Release Injection.....	218
Palyngiq.....	219
Pamidronate Disodium.....	221
Panretin .....	220
Parenteral Bisphosphonates .....	221
Paricalcitol .....	222
Paroxetine Hydrochloride .....	223
Paroxetine Suspension .....	223
Part B Versus Part D .....	389
Pazopanib Hydrochloride.....	40
Pegasys.....	224
Pemazyre.....	40
Pemetrexed.....	40
Pemetrexed Disodium.....	40
Penbraya.....	225
Penciclovir .....	319
Penmenvy.....	226
Pentamidine.....	227
Pentamidine Isethionate .....	227
Pentosan Polysulfate Sodium.....	228
Perampanel.....	229, 230
Perampanel Suspension .....	230
Perjeta .....	40
Pimecrolimus .....	231

Piqray 200mg Daily Dose .....	40	Raldesy.....	244
Piqray 250mg Daily Dose .....	40	Recombivax Hb .....	390
Piqray 300mg Daily Dose .....	40	Redemplo .....	245
Pirfenidone .....	240	Relistor .....	246
Plenaminate .....	390	Repatha .....	247
Plerixafor.....	232	Repatha Sureclick .....	247
Pnv Prenatal Plus Multivitamin + Dha.....	237	Retacrit.....	100
Pomalidomide .....	40	Retevmo .....	40
Posaconazole .....	233	Revcovi .....	249
Posaconazole Dr.....	233	Revuforj .....	40
Potassium Binders .....	234	Reyvow .....	250
Pralatrexate.....	40	Rezdifra .....	251
Praluent .....	235	Rezlidhia .....	40
Prednisone .....	390	Rezurock .....	252
Prehevbrio .....	390	Riabni.....	257
Premasol.....	390	Ribavirin .....	203
Prenatal.....	237	Rinvoq.....	253
Prenatal Vitamins .....	237	Rinvoq Lq .....	253
Pretomanid .....	238	Riociguat.....	255
Prevymis.....	239	Risedronate .....	256
Privigen .....	137	Risedronate Sodium .....	256
Procrit .....	100	Rituxan.....	257
Prograf.....	390	Rituximab.....	257
Prolastin-c .....	381	Rivaroxaban .....	258
Proleukin .....	40	Rivaroxaban Suspension.....	258
Prosol.....	390	Rivfloza.....	259
Prucalopride .....	176	Romidepsin .....	40
Pulmonary Fibrosis Agents .....	240	Romvimza.....	40
Pulmozyme.....	390	Rozlytrek.....	40, 260
Pyquvi .....	71	Rozlytrek Pellet.....	260
Pyrukynd .....	241	Rsv Vaccine .....	261
Pyrukynd Taper Pack .....	241	Rubraca .....	40
<b>Q</b>			
Qbrexza .....	242	Rufinamide.....	262
Qinlock .....	40	Rufinamide Suspension .....	262
Quinine Sulfate.....	243	Ruxience .....	257
<b>R</b>			
Rabavert .....	390	Rybelus.....	263
Radicava Ors .....	94	Rydapt.....	40
Radicava Ors Starter Kit .....	94	Rytary.....	264
Ragwitek .....	202	<b>S</b>	
		Sandostatin Lar .....	265
		Sandostatin Lar Depot.....	265
		Saphnelo.....	266

Sapropterin .....	267
Sapropterin Dihydrochloride.....	267
Savella.....	268
Savella Titration Pack .....	268
Scemblix.....	40
Scopolamine .....	269
Scopolamine Patch .....	269
Secuado .....	270
Sephience .....	271
Signifor.....	272
Siklos.....	273
Sildenafil (pulmonary Arterial Hypertension) ..	274
Sildenafil Citrate .....	274
Simponi .....	275
Simponi Aria .....	275
Sirolimus .....	390
Sirturo.....	276
Skyclaris .....	277
Skyrizi .....	278
Skyrizi Pen .....	278
Sodium Oxybate.....	375
Sodium Phenylbutyrate .....	280
Sofosbuvir/velpatasvir.....	281
Sohonos .....	282
Solifenacin Succinate .....	214
Soltamox .....	283
Somatropins.....	284
Somatuline Depot.....	286
Somavert .....	287
Sorafenib .....	40
Sorafenib Tosylate .....	40
Sotylyze.....	288
Spravato.....	289
Spravato 56mg Dose .....	289
Spravato 84mg Dose .....	289
Spritam .....	290
Stamaril .....	292
Stelara.....	333
Steqeyma .....	333
Stimufend .....	55
Stivarga .....	40
Strensiq.....	293
Sucraid.....	294

Sunitinib Malate.....	40
Symdeko .....	295
Sympazan.....	296
Symproic.....	297
Synarel .....	298
Systemic Testosterone .....	299

## **T**

Tabrecta.....	40
Tacrolimus .....	390
Tadalafil .....	300, 301
Tadalafil (benign Prostatic Hyperplasia) .....	300
Tadalafil (pulmonary Arterial Hypertension) ....	301
Tadliq .....	301
Tafinlar.....	40
Tagrisso.....	40
Takhzyro .....	302
Taltz .....	303
Talzenna.....	40
Tarpeyo .....	305
Tasimelteon.....	123
Tavalisse .....	306
Tavneos .....	307
Tazarotene.....	308
Tazorac.....	308
Tazverik .....	40
Tecentriq .....	40
Tecentriq Hybreza.....	40
Tegsedi.....	309
Temsirolimus .....	40
Tepmetko .....	40
Teriflunomide .....	310
Teriparatide .....	311
Tetrabenazine .....	312
Tevimbra.....	40
Thalomid.....	313
Thiotepa .....	40
Thymoglobulin.....	137
Tibsovo .....	40
Ticovac.....	314
Tigecycline.....	315
Tirosint Solution .....	316
Tirosint-sol.....	316

Tobramycin .....	390	Vectibix .....	41
Tocilizumab .....	317	Veltassa .....	234
Tolterodine Tartrate .....	214	Venclexta .....	41
Tolterodine Tartrate Er .....	214	Venclexta Starting Pack .....	41
Tolvaptan .....	318	Ventavis .....	339
Topical Antivirals .....	319	Veozah .....	340
Topical Diclofenac .....	320	Verkazia .....	341
Topiramate .....	321	Verquvo .....	342
Topiramate Solution .....	321	Versacloz .....	343
Toremifene Citrate .....	41	Verzenio .....	41
Travasol .....	390	Vesicare Ls .....	344
Trelstar Mixject .....	41	Viberzi .....	345
Treprostinil .....	322	Vigabatrin .....	346
Tretinoin .....	41	Vigafyde .....	346
Trikafta .....	323	Vigpoder .....	346
Trintellix .....	324	Viibryd .....	347
Trophamine .....	390	Vijoice .....	348
Tropium Chloride .....	214	Vilazodone Hydrochloride .....	347
Tropium Chloride Er .....	214	Vinblastine Sulfate .....	390
Trulicity .....	325	Vitrakvi .....	41
Trumenba .....	326	Vizimpro .....	41
Truqap .....	41	Vonjo .....	41
Truxima .....	257	Voquezna Dual Pak .....	349
Tryngolza .....	327	Voquezna Pak .....	349
Tryvio .....	328	Voquezna Triple Pak .....	349
Tukysa .....	41	Voranigo .....	41
Turalio .....	41	Voriconazole .....	350
Tymlos .....	329	Vosevi .....	351
Tysabri .....	330	Vowst .....	352
<b>U</b>			
Ubrelvy .....	332	Voxzogo .....	353
Udenyca .....	55	Voydeya .....	354
Udenyca Onbody .....	55	Voyxact .....	355
Ustekinumab .....	333	Vpriv .....	356
Uzedy .....	335	Vyndamax .....	357
<b>V</b>			
Valchlor .....	41	Vyndaqel .....	357
Vanflyta .....	41	Vyvgart Hytrulo .....	358
Vanrafia .....	336	Vyxeos .....	41
Varizig .....	337	<b>W</b>	
Vaxchora .....	338	Wainua .....	359
		Wakix .....	360
		Wayrilz .....	361
		Welireg .....	41

Winrevair..... 362  
Wyost ..... 363

**X**

Xalkori..... 41  
Xatmep ..... 172  
Xcopri..... 364  
Xdemvy ..... 365  
Xeljanz ..... 366  
Xeljanz Xr ..... 366  
Xeomin ..... 32  
Xermelo..... 368  
Xgeva ..... 369  
Xolair..... 370  
Xolremdi ..... 372  
Xospata..... 41  
Xpovio..... 41  
Xpovio 60 Mg Twice Weekly..... 41  
Xpovio 80 Mg Twice Weekly..... 41  
Xromi ..... 373  
Xtandi ..... 41  
Xuriden..... 374  
Xyrem..... 375  
Xywav ..... 376

**Y**

Yargesa..... 379  
Yervoy..... 41  
Yesintek..... 333

Yondelis .....41  
Yonsa .....41  
Yorvipath .....377  
Yutrepia.....378

**Z**

Zaltrap.....41  
Zanosar.....41  
Zarxio.....55  
Zavesca .....379  
Zejula .....41  
Zelboraf.....41  
Zelsuvmi .....380  
Zelvysia.....267  
Zemaira .....381  
Zemaira/prolastin .....381  
Zenatane.....142  
Zilbrysq.....382  
Zinplava .....383  
Zokinvy .....384  
Zoledronic Acid .....221  
Zolinza .....41  
Zonisade.....385  
Zorbtive.....284  
Ztalmy .....386  
Zurzuvae .....387  
Zydelig .....41  
Zykadia .....41  
Zyprexa Relprevv.....388